RHODE ISLAND MEDICAID PROGRAM

ANNUAL REPORT
FISCAL YEAR 2004

building health care programs to meet community needs

long term care initiative • pregnant women • breast and cervical cancer program

TBI implementation grant • elderly adults • aged and disabled waiver program

PACE grant • RIte Care for children and families • chronic care programs

drug utilization review • State Health Insurance Program Title XXI • medical transportation

adults with disabilities • nursing facility transitions grant • children under age 19

real choice systems change grant • CEDARR family center • RIte Share

lead centers • children with special health care needs • foster care initiative

MESSAGE FROM THE DIRECTORS

Access to appropriate, effective health care remains a priority in Rhode Island. Rhode Island Medicaid cares for some of the state's most vulnerable populations and is an integral part of the state's overall health care system, serving 17 percent of Rhode Islanders.

The Department of Human Services produces the Medicaid Annual Report to provide the legislature, the administration and the public with information that will help these groups make informed decisions about Medicaid services and programming. The three sections of this year's report describe: **(1)** Medicaid's structure, financing and eligibility rules; **(2)** the programs, populations, expenditures and evaluation efforts overseen by DHS' Center for Adult Health; and **(3)** the programs, populations, expenditures and evaluation efforts overseen by the Center for Child and Family Health. Under new 2004 requirements of RI General Laws Section 42.12.27,for the first time, the Department of Human Services is reporting on sub-populations within children with special health care needs, including: children in substitute care, children covered through SSI or the Katie Beckett eligibility provisions and children in subsidized adoption. The report covers all Rhode Island Medicaid expenditures, including those made through other state departments and local school districts.

In State Fiscal Year 2004, Medicaid spent $1.72 billion in state and federal funds to provide health care services to an average of 182,625 people each month. Medicaid provides access to health care for a range of populations including: elderly, persons with disabilities, children and families, and children with special health care needs.

Given that the elderly and adults with disabilities are a growing segment of Rhode Island's population, fiscal year 2004 saw a renewed emphasis on developing a statewide strategic vision for chronic and long-term care services. Adults with disabilities and the elderly account for 25 percent of the Medicaid population and 66 percent of total expenditures. The 25,330 adults with disabilities enrolled in Medicaid in fiscal year 2004 represent a three percent increase from 2003, while the elderly population increased two percent to 19,665. Overall, the expenditures for the adult population with disabilities under age 65 reached $557 million in 2004, an average of $1,834 per client per month. Over $425 million was spent on services for the aged, with an average monthly per client cost of $1,725.

Efforts to stabilize the growth of the successful RIte Care program continued in fiscal year 2004 as a greater number of RIte Care eligible children and families were enrolled in employer-sponsored health care coverage through RIte Share. By enrolling children and families in RIte Share, the state pays only the employee portion of the employer-sponsored premium instead of 100 percent of the premium under RIte Care. Total expenditures for 123,761 children and families in RIte Care and RIte Share were $317 million in fiscal year 2004. The average monthly per client expenditure (including in-plan and out-of-plan services) for RIte Care was $206 and for RIte Share, the average monthly per client expenditure was $119. Overall, an average of 13,869 children with special health care needs were Medicaid eligible each month in fiscal year 2004. Total Medicaid spending on this population rose to $192 million, with an average monthly expenditure of $1,409 per child.

Rhode Island Medicaid continues to work hard to meet the challenges of improving the health and health care of the state's most vulnerable populations. The Department of Human Services and its partners are committed to increasing access and quality of care while containing costs, as we continue *Building Health Care Programs to Meet Changing Community Needs.* ▼

Jane A. Hayward
Managing Director
Office of Health & Human Services

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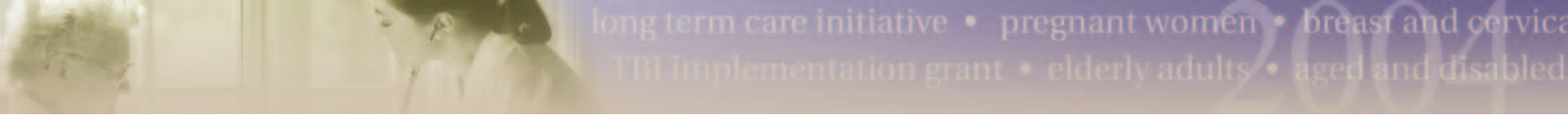


INTRODUCTION, ADMINISTRATION & OVERVIEW

INTRODUCTION

The Rhode Island Department of Human Services produces the Medicaid Annual Report as part of its role as the designated agency responsible for Medicaid. The Rhode Island Department of Human Services (DHS) is the Medicaid single state agency responsible to the federal government and the state for the effective, efficient administration and supervision of Rhode Island Medicaid and for assuring statewide accessibility to a comprehensive system of high-quality health care services for Medicaid recipients.

The Department began compiling an annual report on Medicaid in fiscal year 1999. The report was prepared in response to a request from state policymakers for additional information about Medicaid expenditures to assist in evaluating program outcomes and promote greater fiscal accountability.

Using information from fiscal year 2003 for comparison, the fiscal year 2004 annual report provides updates on changes in Medicaid populations and program expenditures. The report highlights the activities of the Center for Adult Health (which serves adults with disabilities and the elderly) and the Center for Child and Family Health (the Center serving children and families, and children with special health care needs). The report outlines current program services and initiatives, summarizes health care expenditures and utilization rates and describes efforts at measuring access, quality and outcomes.

Rhode Island has seized every opportunity to use the greater flexibility the federal government has given the states over the past ten years, expanding access to and improving the quality of Medicaid health care services and coverage. The state has made particular efforts to extend coverage to new population groups in order to improve health care outcomes and decrease the rate of uninsurance in the state. While Rhode Island, like other states, has seen an increase in the number of uninsured residents, efforts to provide insurance coverage have helped to keep the uninsurance rate low, relative to other states. In 2004, Rhode Island's rate of uninsurance was 10.2 percent, although an increase from the previous year, the state was the second lowest in the nation. In addition, Rhode Island has used its Waiver authority to provide specialized services to individuals who can benefit from them. These efforts have improved the lives of many adults with disabilities and elderly individuals who now have the option to obtain care in the community rather than in institutions.

When Medicaid began in the mid-1960s, the program was modeled on the indemnity health insurance plans that dominated the private market at that time. Under this "fee-for-service" model, Medicaid became a payer of medical claims incurred by its beneficiaries. A Medicaid recipient first identified a provider who would accept Medicaid's "fee-for-services performed" and then went to the provider for care. The provider submitted a bill to Medicaid, which Medicaid then paid. While some argue that a passive role is the natural order for a government-run program, others contend that this approach ignores the state's considerable potential to leverage the program's spending volume. This leverage enables Medicaid to conduct **value-based purchasing** in order to optimize the balance between the quantity, quality, and cost of services.

INTRODUCTION - CONTINUED

Throughout the 1990s, the Rhode Island Medicaid program, like others across the country, leveraged its purchasing power to transition from "payer" to "purchaser." Value-based purchasing involves contracting upfront with an organization that accepts payment for an agreed upon price for a specified service or range of services to Medicaid clients. The state, as the purchaser, sets standards (e.g., quality of care standards) for which the contracting organization is held accountable.

As a purchaser, the state can obtain services for all clients or subgroups of clients. The state can purchase one service, a specified range of services, or all Medicaid covered services. It can contract with one or many organizations/providers as needed. This process requires the state to develop and enforce contractual standards for health care quality and access. Value-based purchasing necessitates a good quality management system, including negotiated performance measures, member satisfaction surveys and focus groups, independent external reviews, data reporting and analysis, and continuous quality improvement systems.

Over time, RI Medicaid has been shifting from being an after-the-fact payer of services to a value-based purchaser that can leverage its buying power to secure better and more cost-effective services and delivery systems for enrollees. This value-based purchasing principle enables Medicaid to promote better outcomes for the consumer and to gain more overall value for the public dollar.

Rhode Island Medicaid has also made changes to the range of populations it serves and the service delivery options it offers. Although Medicaid served a fairly limited population at its inception, state programs have been given incremental leeway to expand the individuals and families they cover. Rhode Island has chosen to provide Medicaid coverage to a number of optional groups. States can provide optional services, for which they receive federal matching funds.

The federal government requires the states to provide all Medicaid recipients with services that are comparable in scope, amount and duration. In the early 1980s, states were given the option to waive this and several other Medicaid requirements. Rhode Island established its first two Waivers in 1983, and now administers six Home and Community Based Services (HCBS) Waiver programs.

Rhode Island also administers a Section 1115(a) "research and demonstration" Waiver. Section 1115(a) Waivers allow states to explore new approaches to benefits, services, eligibility, program payments and service delivery. In 1994, Rhode Island used a Section 1115(a) Waiver to implement RIte Care, the state's Medicaid managed care program for eligible children and families. ▼

WHAT IS MEDICAID?

Medicaid is a federal/state sponsored health care program for individuals and families with limited incomes and resources. The program was established by the federal government in 1965 as Title XIX of the U.S. Social Security Act.

In the years since the program was created, Medicaid has become both the primary payer and purchaser of health care for many individuals and families in need. Today, Medicaid is the chief source of funding for: long-term care for individuals with limited-means; health care services for low-income adults with disabilities; and health care coverage for low-income families and their children and pregnant women and infants.

The federal government establishes core requirements concerning Medicaid funding, eligibility standards, and the quality and scope of medical services. Medicaid is an entitlement program; anyone who meets specified eligibility criteria may receive Medicaid services. Within this structure, states have flexibility to determine certain aspects of their own programs in the areas of eligibility, reimbursement rates, benefits and service delivery.

Title XIX requires that each state maintain a Medicaid State Plan that identifies the populations served, the criteria for determining eligibility, the scope of services provided, and the method of service delivery. The Medicaid State Plan is submitted for approval to the U.S. Centers for Medicare and Medicaid Services (CMS), the federal agency with oversight responsibility for state Medicaid programs. The Medicaid State Plan is an evolving rather than fixed document. A state must continually amend and/or revise its state plan to reflect the changes made in Medicaid program priorities and requirements.

Federal law also requires each state to centralize administrative, legal and financial responsibility for its Medicaid program in a "single state agency." The unit of government designated as such maintains the Medicaid State Plan, purchases the health care services and coverage authorized therein, and coordinates their delivery statewide. In Rhode Island, the single state agency is the Department of Human Services.

The Balanced Budget Act of 1997 added a new section to the Social Security Act - Title XXI. Title XXI established the State Children's Health Insurance Program (SCHIP), a federal/state program designed to provide health insurance coverage to previously uninsured children. Each state designed its own program within established federal guidelines. Rhode Island built on its previous expansion of child and family coverage by using SCHIP funding to expand its existing Medicaid program to cover more children.

For a detailed history of the Medicaid program see the DHS website *www.dhs.ri.gov* ▼

ADMINISTRATION OF RHODE ISLAND MEDICAID

The Department of Human Services is the designated single state agency with responsibility and accountability for the Medicaid program in Rhode Island. As the single state agency, DHS has statutory responsibility for:

1. **Oversight of the Medicaid State Plan.** The DHS must administer or supervise the implementation of all aspects of the Medicaid State Plan, including ensuring the correctness and accuracy of all financial and program reports as well as overseeing the scope and accessibility of services. The DHS cannot delegate its duties and responsibilities to other state or local agencies, although DHS is specifically authorized to enter into cooperative arrangements with other state and local agencies to maximize the utilization and coordination of medical assistance within Rhode Island.
2. **Statewide service availability, adequacy, quality.** The DHS is required to ensure that Medicaid services are available statewide.
3. **Statewide access to efficient eligibility determination.** The DHS is required to provide all Rhode Island residents with the opportunity to apply for medical assistance, assure that eligibility will be appropriately determined, and make sure that the state will furnish medical assistance with reasonable promptness, in a manner consistent with simplicity of administration and the best interests of the recipients.
4. **Choice of and equitable access to service providers.** The DHS is required to assure that individual recipients have a choice of providers both within the fee-for-service and managed care components of the program, while at the same time assuring that methods and payment rates are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available to the Medicaid population in all geographic areas of the state.
5. **Sufficient availability of basic services, including the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.** The DHS is required to assure that services are of sufficient amount, duration and scope for both mandatory and optional services; and that EPSDT screenings and necessary medical services are available to Medicaid eligible persons under age 21.

Each state must determine how to administer the program across multiple agencies that have overlapping responsibilities and authorities to serve a variety of eligible populations. As indicated in (1) above, DHS may enter into cooperative agreements with other state agencies in order to maximize the utilization and coordination of services for the Medicaid population; however, DHS cannot delegate its duties or responsibilities.

Within these parameters and under Rhode Island state statutes, the Department of Human Services has shared stewardship for Rhode Island Medicaid with other agencies:

- Department of Mental Health, Retardation and Hospitals (MHRH)
- Department of Children, Youth and Families (DCYF)
- Department of Health (DOH)
- Department of Elderly Affairs (DEA)
- Local Education Agencies (LEAs)

The relationships that constitute this shared stewardship are complex. **Exhibit 1** illustrates the services that are either purchased or provided by each state agency on behalf of the four Medicaid population subgroups.

EXHIBIT 1

Rhode Island Medicaid Purchased and Directly Provided Services by Department FY 2004

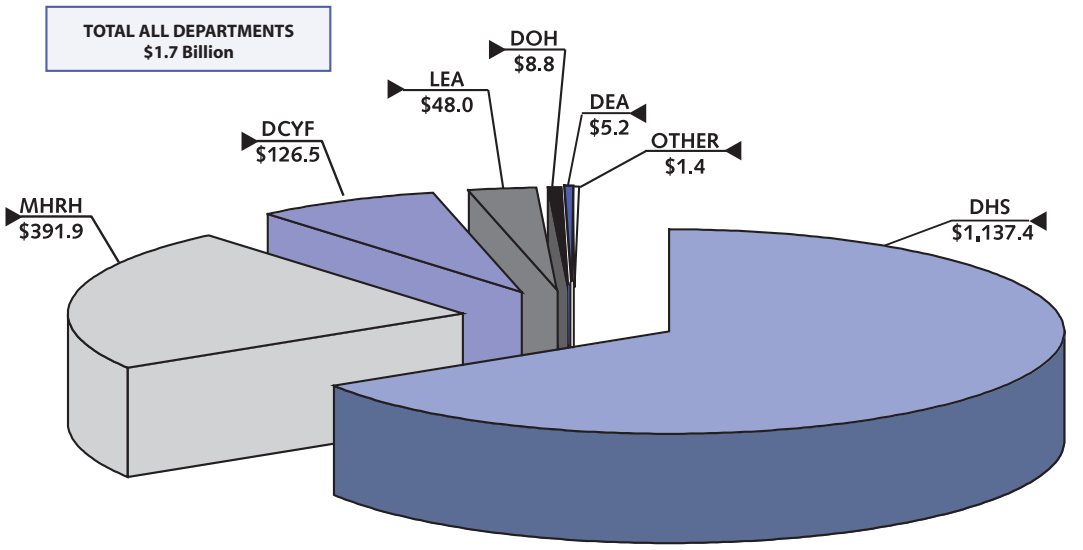
Population	Department of Human Services	Department of Children, Youth and Families	Department of Mental Health, Retardation and Hospitals	Department of Elderly Affairs	Department of Health	Local Education Agencies
Adults with Disabilities	Basic Medicaid services through direct pay to fee-for-service providers; Home and community based services		Behavioral health services to adults with severe and persistent mental illness; Substance abuse treatment; Certain home and community based services including group homes for adults with developmental disabilities and mental retardation; Slater Hospital	Certain home and community based services	Targeted case management for people with AIDS State laboratory	
Elderly Adults	Basic Medicaid services through direct pay to fee-for-service providers; Home and community based services		Behavioral health services to adults with severe and persistent mental illness; Substance abuse treatment; Certain home and community based services including group homes for adults with developmental disabilities and mental retardation; Slater Hospital	Certain home and community based services	State laboratory	
Children and Families in Managed Care	Basic Medicaid services through Health Plans plus fee-for-service wrap-around services; CEDARR Family Services	Certain behavioral health services	Substance abuse treatment		State laboratory	Case management and school-related services; Individualized education plans (IEPs) for Medicaid-eligible special education students
Children with Special Health Care Needs	Basic Medicaid services through direct pay to fee-for-service providers; Comprehensive Evaluation, Diagnosis, Assessment, Referral and Re-evaluation (CEDARR) family services	Residential placement; Certain behavioral health services	Substance abuse treatment		State laboratory	Case management and school-related services; Individualized education plans (IEPs) for Medicaid-eligible special education students

ADMINISTRATION - CONTINUED

Exhibit 2 illustrates the total FY 2004 state and federal expenditures for the Medicaid program by department. For a listing of programmatic partnerships and participating Departments and other stakeholders, please see the DHS web site at *www.dhs.ri.gov*.

Exhibit 3 displays the eligibility pathways and the service delivery system options available to each subgroup. The population has been divided into these four categories based on similarities of service need and complexity, as related to age, family structure and disability.

EXHIBIT 2
RI Medicaid Total Expenditures by Department in Millions - FY 2004



DHS - Department of Human Services
MHRH - Department of Mental Health, Retardation and Hospitals
DCYF - Department of Children, Youth and Families
LEA - Local Education Agencies
DoH - Department of Health
DEA - Department of Elderly Affairs

EXHIBIT 3

Rhode Island Medicaid Eligibility Pathways and Delivery System Options (as of June 30, 2004)

Medicaid Population Subgroup	Eligibility Pathways	Delivery System Options
Children and families in managed care **(Children under 19 and their parents)**	• FIP/TANF • Section 1115(a) Waiver eligible • SCHIP • Certain poverty level children who are not eligible for TANF • 1931(e) Expansion parents	• Enrollment in a RIte Care Health Plan or Rite Share Premium Assistance Program plus limited FFS to fill in gaps in coverage • CEDARR
Children with special health care needs (as an eligibility factor) **(Under age 22)**	• Children who are – Blind and disabled SSI recipients – Katie Beckett eligible (eligible up to 18th birthday) – in Substitute care – in Subsidized adoption	• Traditional Fee-for-Service (FFS) • Enrollment in a RIte Care Health Plan plus limited FFS to fill in gaps in coverage • CEDARR
Adults with disabilities **(Age 22-64)**	• Blind and disabled SSI recipients • Medically needy • Medicare recipients below certain income level • Long term care eligible	• Traditional FFS • Connect CARRE • Waiver programs – Mentally Retarded and Developmentally Disabled (MHRH) – Aged and Disabled – Physically Disabled (PARI) – Assisted Living (DEA)
Aged **(Age 65 and over)**	• Aged, blind and disabled SSI recipients • Medically needy • Medicare recipients below the poverty level	• Traditional FFS • Assisted Living Waiver (DEA) • Elderly Waiver (DEA) • Aged and Disabled Waiver • Physically Disabled (PARI) • Mentally Retarded and • Developmentally Disabled Waiver (MHRH)

ADMINISTRATION - CONTINUED

Within DHS, the Division of Health Care Quality, Financing and Purchasing (the "Division") is responsible for administering the Rhode Island Medicaid program. The Division's program development, administration and staff are located in three centers:

- Center for Adult Health
- Center for Child and Family Health
- Center for Finance and Administration

The Division has been implementing its consumer-focused value-based purchasing philosophy by adopting the following operating principles to develop and manage its programs:

- Assess consumer needs.
- Involve consumers in the services they receive.
- Involve providers in defining performance expectations that respond to consumer needs and assure the quality and accountability of service provision.
- Define benefits, design payment methodologies and create contract structures that support:
  - The improved health status of the consumer
  - The ability to obtain and maintain work opportunities for those with disabilities
  - The cost-conscious expenditure of public funds; and
  - The use of data to track progress, inform decisions and continuously improve programs.

The Center for Adult Health (CAH) and the Center for Child and Family Health (CCFH) are responsible for program and policy development for the four Medicaid population subgroups. The activities of these two Centers are discussed in detail within the sections that follow.

In addition to administering programs for adults with disabilities and elderly adults, CAH oversees the Medicaid Management Information System (MMIS) on behalf of the Division. The MMIS processes medical claims, makes capitation payments, enrolls providers, maintains eligibility information and utilization reports. The Division is responsible for developing policies and procedures as well as monitoring the activities of its fiscal agent, Electronic Data Systems Corporation (EDS), as related to claims processing, provider relations and report generation.

As coordinator of the MMIS function, CAH has major responsibility for the implementation of and compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The intent of this federal legislation is to improve the availability and portability of health coverage through a variety of provisions. In addition, HIPAA, through its Administrative Simplification provision, requires the adoption of national standards for the electronic transfer of health care information including codes, identifiers, security and privacy. HIPAA requires that covered-entities, which include healthcare providers, insurers and healthcare claim billing clearinghouses, comply with published Federal rules or become subject to civil and criminal fines and sanctions. The RI Department of Human Services is the single-state agency responsible for ensuring that Medicaid operations, including those programs co-administered by several sister State agencies, become compliant with HIPAA regulations. Medicaid operations are widely dispersed within RI State government; therefore, a cohesive and coordinated effort has been necessary to ensure that all Federal mandates are implemented.

ADMINISTRATION - CONTINUED

In addition to administering programs for children and families in managed care, children with special needs and children in foster care, CCFH oversees research and evaluation on behalf of the Division. The approach to research and evaluation originates from Medicaid's overarching goal, "to improve the health of the Medicaid population and, by so doing, improve the health of Rhode Island's population overall." Rhode Island Medicaid is working to ensure that programs measurably improve the health of the Medicaid population, and so need to be able to measure progress toward that goal. Research efforts assist programs by measuring and assessing progress. Information related to research and evaluation initiatives can be found on the RIte Care research web site at *www.ritecareresearch.org*.

The Center for Finance and Administration (CFA) encompasses all the core administrative functions of the Medicaid program: budgeting; financial expenditure analysis; financial control of the MMIS; financial reporting; hospital-related service monitoring and payment; program integrity; recoveries from third parties for claims liability; estate recoveries; and calculation and distribution of the disproportionate share program (DSH) for uncompensated care in Rhode Island hospitals.

The CFA administers the Prospective Hospital Reimbursement Program as the Department of Administration's designee. This program has its origins in state law. In 1971, amendments were added to the enabling legislation for nonprofit hospital service corporations, i.e., Blue Cross of Rhode Island. These amendments mandated that hospital budget negotiations are necessary for the purpose of determining payment rates for hospitals.

The current participants in the program are the State of Rhode Island, the thirteen voluntary hospitals in the state and Blue Cross of Rhode Island. The major components of the program are: a negotiated statewide maximum ceiling on reimbursable expenses (MAXICAP); negotiated individual hospital operating budgets; and establishment of third-party payment rates for inpatient and outpatient services.

WHO IS ELIGIBLE?

All state Medicaid programs must cover the following people:

1. Recipients of Supplemental Security Income (SSI) or Supplemental Security Disability Insurance (SSDI)[1];
2. Low income Medicare beneficiaries.
3. Individuals who would qualify for Aid to Families with Dependent Children Program (AFDC) today under the state's 1996 AFDC eligibility requirements [2];
4. Children under age six and pregnant women with family income at or below 133 percent of federal poverty guidelines;
5. Children born after September 30, 1983, who are at least age five and live in families with income up to the federal poverty level;
6. Infants born to Medicaid-enrolled pregnant women;
7. Children who receive adoption assistance or who live in foster care, under a federally-sponsored Title IV-E program;

In addition, Rhode Island Medicaid has chosen to cover these optional groups:

1. Low-income elderly adults or adults with disabilities;
2. Individuals eligible for Home and Community Based Services Waiver programs.
3. Children and pregnant women up to 250 percent and parents up to 185 percent of the federal poverty level, including children funded through the State Children's Health Insurance Program (SCHIP);
4. Individuals determined to be "medically needy" due to low income and resources or to large medical expenses;
5. Children under 18 with a disabling condition severe enough to require institutional care, but who live at home (the "Katie Beckett" provision);
6. Women eligible for the breast and cervical cancer program.

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1. SSI is a federal income assistance program for disabled, blind or aged individuals that is independent of individuals' employment status. SSDI is an insurance program for those who have worked a specified amount of time and have lost their source of income due to a physical or mental impairment.
2. Federal policymakers severed the tie between medical and cash assistance when the AFDC program was replaced in 1996. The AFDC standard was retained in Title XIX to prevent the states from using the more restrictive eligibility requirements and time limits of AFDC's successor - Temporary Assistance for Needy Families or TANF - when providing Medicaid coverage to needy children and families.

WHO IS ELIGIBLE? - CONTINUED

Within DHS, the Division of Health Care Quality, Financing and Purchasing administers the Rhode Island Medicaid program. The program manages services for four population subgroups across two Centers:

The Center for Adult Health manages:

- Adults with disabilities; and
- Elderly adults

The Center for Child and Family Health manages:

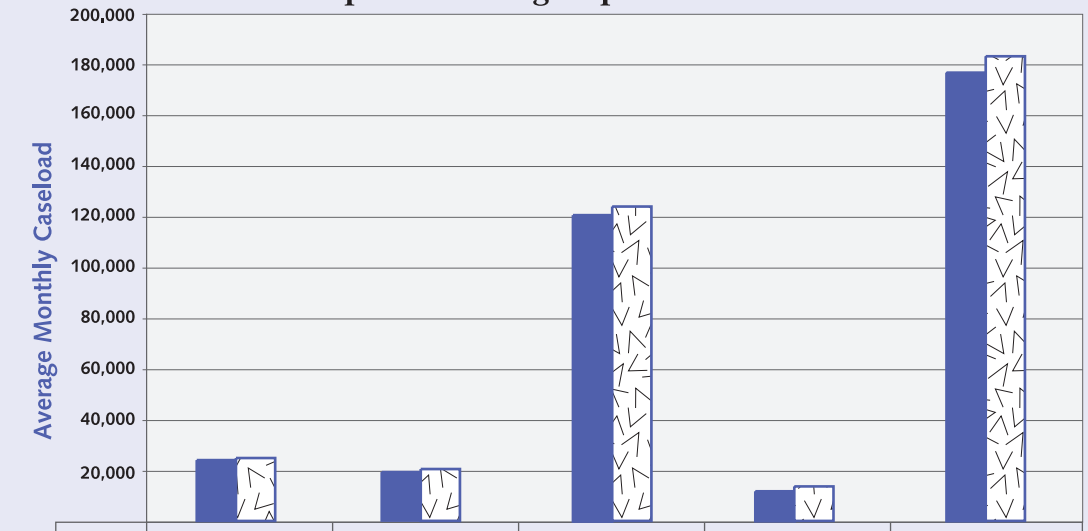
- Children and families in managed care including:
  - RIte Care
  - RIte Share
- Children with special health care needs,
  - Children eligible due to SSI or the Katie Beckett provision
  - Children in Subsidized Adoption
  - Children in Foster Care

Exhibit 4 displays the average monthly caseload[3] of Medicaid recipients by subgroup for fiscal year 2004. The total of 182,625 recipients are distributed as follows:

- 25,330 adults with disabilities
- 19,665 elderly adults
- 123,761 children and families in managed care (includes 5,127 RIte Share enrollees)
- 13,869 children with special health care needs

EXHIBIT 4

Rhode Island Medicaid Average Monthly Caseload by Population Subgroup FY2003 & FY2004



Subgroup	Adults with Disabilities	Elderly	Children & Families in Managed Care*	Children with Special Health Care Needs**	TOTAL
SFY 2003	24,543	19,237	120,895	12,149	176,824
SFY 2004	25,330	19,665	123,761	13,869	182,625

*includes RIte Share
**includes children in foster care

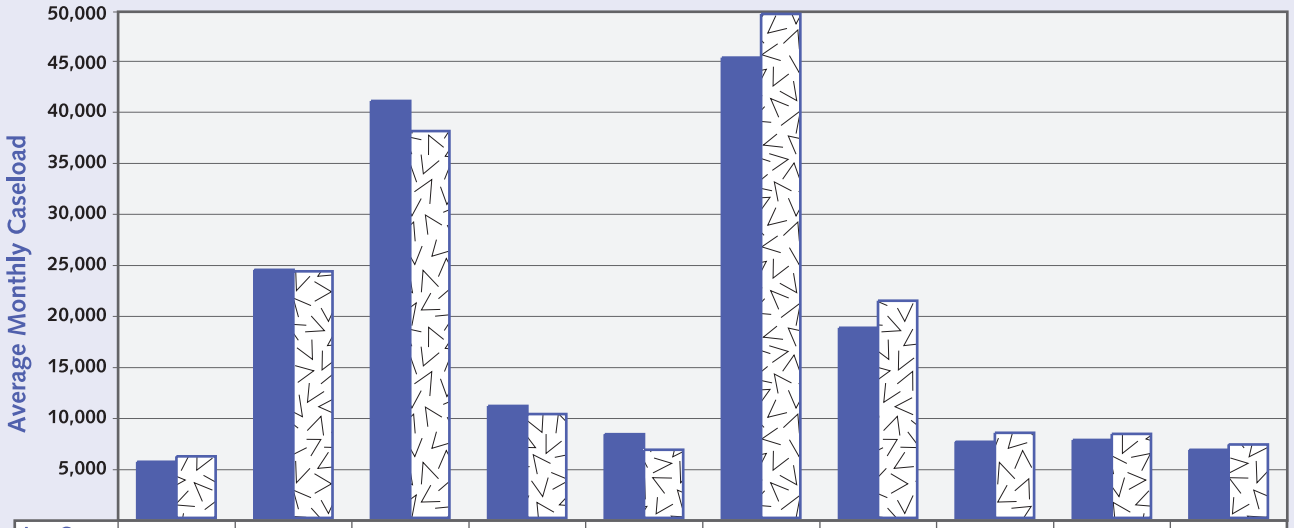
3. The average monthly caseload of Medicaid recipients represents the number of individuals enrolled in a given month regardless of the length of time they were eligible (from 1 to 31 days). The average monthly caseload for the year is calculated by averaging the monthly caseload for 12 months. The unduplicated count of Medicaid recipients represents the number of unique individuals enrolled during the year regardless of the length of time they were eligible (from 1 to 365 days). The unduplicated count is higher than average monthly caseload. Average monthly caseload is used in most budgeting and financial calculations and in the caseload estimating conferences

WHO IS ELIGIBLE? - CONTINUED

Exhibit 5 displays the FY 2004 Medicaid population by age group.

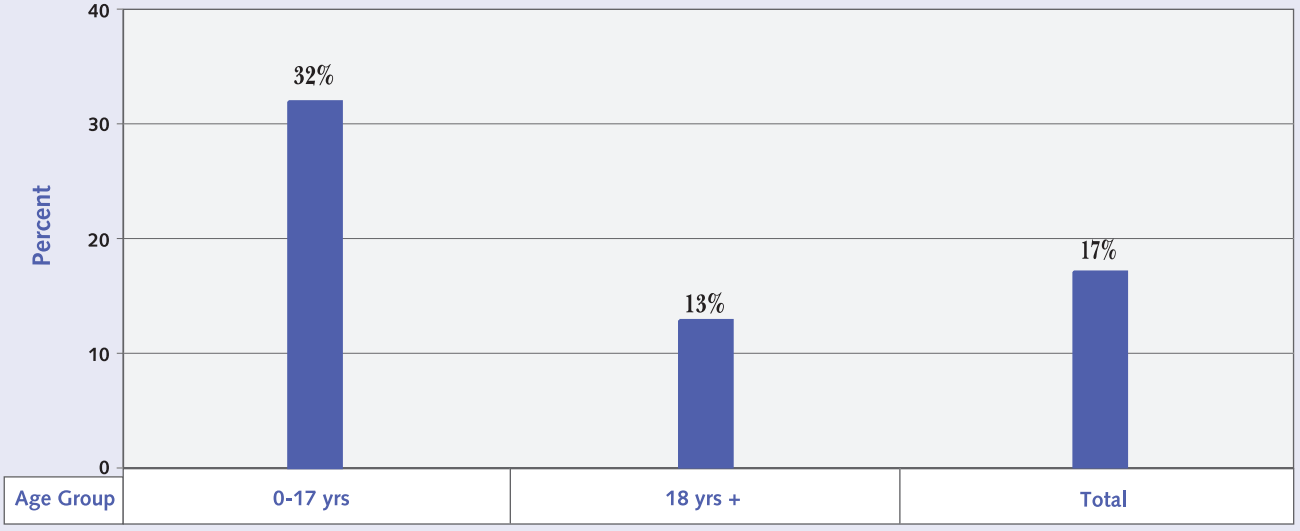
Exhibit 6 displays the Medicaid population as a percent of the Rhode Island populations of children and of adults. Overall, Medicaid recipients made up 17 percent of the state population. Medicaid covered an estimated 32 percent of all Rhode Island children under age 18 years and 13 percent of persons 18 years and older during 2004.

EXHIBIT 5
Rhode Island Medicaid Average Monthly Caseload by Age Group FY 2003 & FY 2004



Age Group	0-1 yrs	1-5 yrs	6-14 yrs	15-17 yrs	18-21 yrs	22-44 yrs	45-64 yrs	65-74 yrs	75-84 yrs	85 yrs +
FY 2003	5,825	24,442	41,043	11,250	8,221	45,091	18,816	7,545	7,757	6,833
FY 2004	6,103	24,092	38,042	10,209	6,685	49,454	21,352	8,259	8,401	7,290

EXHIBIT 6
Rhode Island Medicaid Average Monthly Caseload as a Percent of Rhode Island Population FY 2004



Sources: US Census 2000
RI Medicaid Program Data

WHAT SERVICES ARE COVERED?

Exhibit 7 lists the services covered by Rhode Island Medicaid. All recipients are eligible to receive "Basic Medicaid Services" unless otherwise specified. Please note that:

- To be eligible as medically needy, a recipient must have income and resources below specified limits, or have large medical expenses;
- To be eligible for Waiver services, recipients must meet specific criteria. (For information on Waiver programs, please see the DHS web site at www.dhs.ri.gov)
- To be eligible to participate in federal Medicare buy-in, a recipient must meet Medicare requirements and have income and resources below specified limits.

EXHIBIT 7
Rhode Island Medicaid State Plan Services
FY 2004

Basic Medicaid Services — Mandatory State Plan Services plus Optional State Plan Services offered in RI, i.e.:

Mandatory State Plan Services

States are required to offer coverage to the categorically needy for these services:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and x-ray services
- Nursing facility services for individuals 21 and older
- Early & periodic screening, diagnostic and treatment services (EPSDT) for individuals under age 21
- Family Planning services
- Physicians' services
- Home health services for any individual entitled to nursing facility care
- Nurse-midwife services to the extent permitted by State law
- Services of certified nurse practitioners and certified family nurse practitioners to the extent they are authorized to practice under State law
- Services of certified nurse practitioners and certified family

Optional State Plan Services offered in RI

- Podiatrists services
- Optometrists services
- Dental services
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Diagnostic services
- Preventive services
- Rehabilitative services
- Services in an IMD for individuals age 65 and over
- Inpatient psychiatric services for individuals under age 21
- NF services for individuals under age 21
- Personal care services
- Transportation services
- Case management services
- Hospice services
- TB services for certain TB infected individuals

Medically Needy State Plan Services — Prenatal & delivery for pregnant women, ambulatory services for individuals under 18 and those entitled to institutional care, home health services for individuals entitled to nursing facility services, mandatory state plan services for over 65 & under 21 in an IMD or ICF/MR.

Waiver Services — Home or community based services not otherwise furnished under the State's Medicaid plan and have been approved under a waiver request to HCFA. These consist of any or all of the following: case management services, homemaker services, personal care services, adult day health services, habilitation services, respite services, minor assistive devices, minor modifications to the home, and other medical or social services as requested by the state and found to be cost-effective to prevent institutionalization.

Federal Medicare Buy-in — Direct payment or annual stipend to pay Medicare deductibles, co- payments and coinsurance, only.

Employer Sponsored Health Insurance (ESI) Premium Assistance — If cost-effective, the state pays the employees share of ESI premium if Medicaid eligible has access to ESI.

Enrollee Co-premium — Under managed care programs for children and familes, enrollees must pay a sliding scale co-premium based on family income.

HOW IS MEDICAID FINANCED?

Exhibit 8 displays Rhode Island's FMAP rate from 2001 through 2006 for Title XIX (Medicaid) and Title XXI (State Children's Health Insurance Program (SCHIP)[4] expenditures. Medicaid enrollment is not limited based on a pre-set expenditure cap. By federal law, eligible individuals cannot be denied enrollment or covered services based on insufficient government funds.

Exhibit 9 shows total combined federal and state expenditures for Rhode Island Medicaid in FY 2004. Total expenditures for benefits and administration were $1.72 billion. Medicaid expenditures constitute a sizable proportion of the total state budget. In fiscal year 2004, Medicaid accounted for 26.2 percent of the state budget.

HOW ARE MEDICAID DOLLARS USED?

Exhibit 10 displays Medicaid expenditures by population group. Total program expenditures grew 11 percent between fiscal years 2003 and 2004. The largest absolute increase, i.e., $57 million occurred in the adults with disabilities subgroup. The largest percentage increase, i.e., 12 percent, occurred in the children and families in managed care.

4 Through SCHIP, the federal government provides states with an "enhanced" FMAP rate to encourage enrollment of children in the program.

EXHIBIT 8
RI Medicaid State & Federal Matching Rates 2001 to 2006

MEDICAID TITLE XIX		
Federal FY	**State %**	**Federal %**
2001	46.21%	53.79%
2002	47.55%	52.45%
2003*	43.13%	56.87%
2004*	41.76%	58.24%
2005	44.62%	55.38%
2006	45.55%	54.45%
SCHIP TITLE XXI		
Federal FY	**State %**	**Federal %**
2001	32.35%	67.65%
2002	33.28%	66.72%
2003	31.22%	68.78%
2004	30.78%	69.22%
2005	31.23%	68.77%
2006	31.88%	68.12%

Source: Center for Medicare and Medicaid Services
*under PL. 108-27, the Jobs and Growth Reconciliation Act, the federal match was increased by 2.95 points so that from April 2003 to September 2003 the FMAP was 58.35% and from October 2003 to June 2004 the FMAP was 59.98%

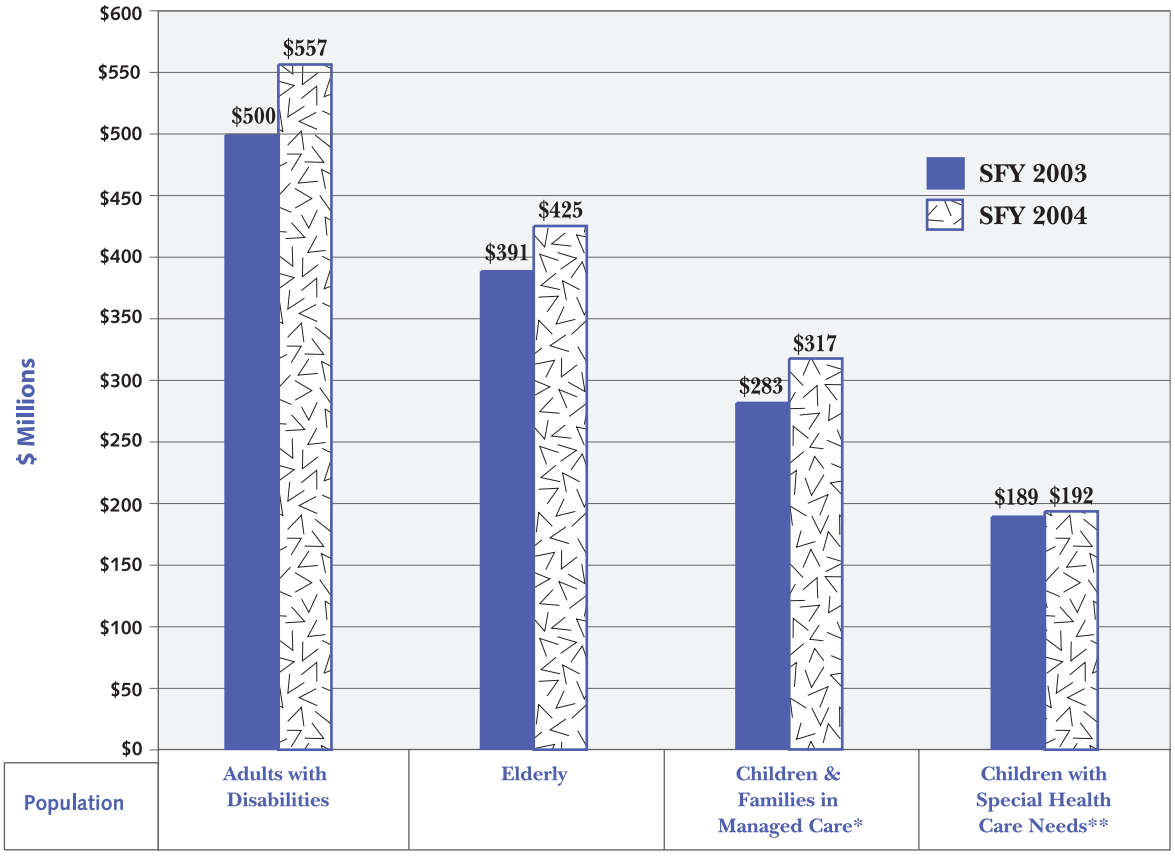
EXHIBIT 9
Rhode Island Medicaid Total Expenditures FY 2004

Line Items/ Departments	Expenditures	Percent
Hospital - Regular	$ 124,715,403	7.3%
Hospital - Disproportionate Share payments	$ 107,285,176	6.2%
Nursing Homes	$ 291,981,426	17.0%
Managed Care	$ 328,511,599	19.1%
Other	$ 238,207,230	13.9%
Restricted Receipt	$ 8,981	0.0%
Administration-DHS	$ 46,658,457	2.7%
Total DHS	$1,137,368,272	66.2%
Total MHRH	$ 391,906,077	22.8%
Total DCYF	$ 126,536,229	7.4%
Total LEA	$ 47,958,644	2.8%
Total DOH	$ 8,757,577	0.5%
Total DEA	$ 5,153,754	0.3%
Total Other	$ 1,371,227	0.1%
TOTAL ALL DEPARTMENTS	**$1,719,051,780**	**100.0%**

DHS: RI Department of Human Services
MHRH: RI Department of Mental Health, Retardation and Hospitals
DCYF: RI Department of Children, Youth and Families
LEA: Local Education Authorities
DOH: RI Department of Health
DEA: RI Department of Elderly Affairs

EXHIBIT 10

Rhode Island Medicaid Program Expenditures by Population Subgroup - FY 2003 and FY 2004 ($ in Millions)



* includes RIte Share
** includes children in foster care

HOW ARE MEDICAID DOLLARS USED?

Exhibit 11 compares the caseload distribution for each subgroup with the associated distribution of expenditures. While children and families in managed care represent 68 percent of the total caseload, they account for only 21 percent of program expenditures. Conversely, adults with disabilities and the aged combined represent 25 percent of the total caseload but account for 66 percent of all expenditures. In addition, children with special health care needs represent 8 percent of total caseload and account for 13 percent of all expenditures.

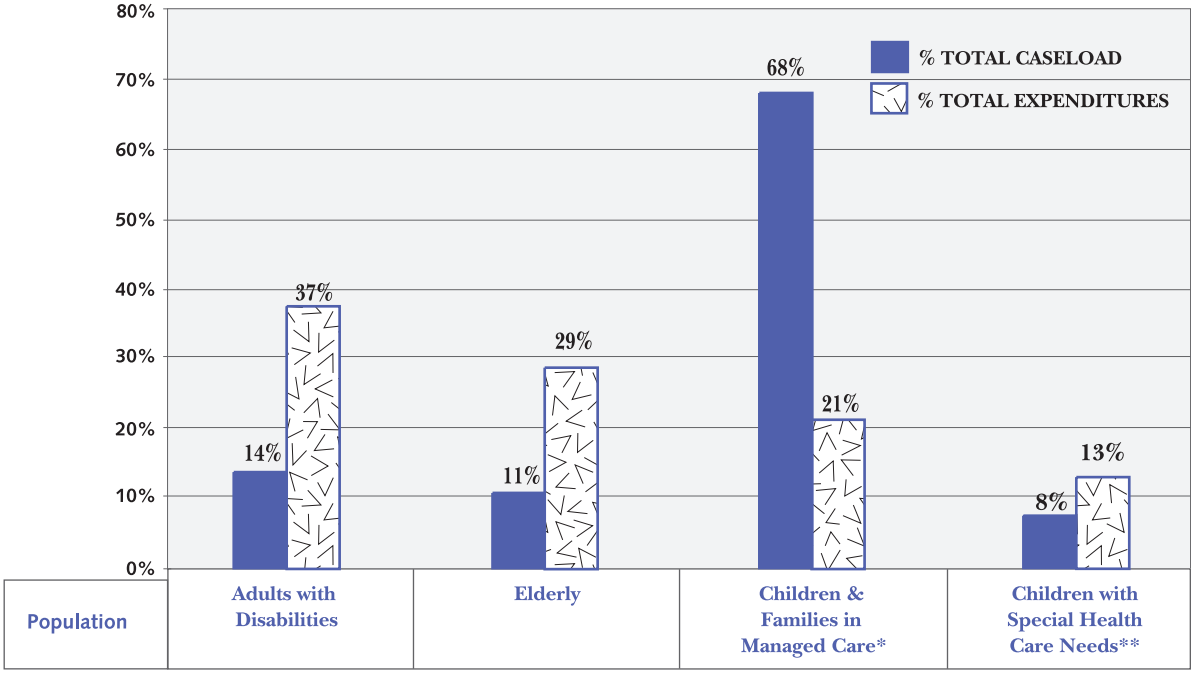
Exhibit 12 displays medical expenditures by category of service provider, ranked by expenditure volume:

- $400 million for home and community based services
- $386 million for institutional service providers (nursing homes and Eleanor Slater Hospital)
- $206 million for pharmaceuticals
- $192 million for acute-care hospitals
- $173 million for physicians and other services
- $135 million for providers of behavioral health services

Average per capita per month (PCPM) costs are shown in **Exhibit 13**. The per capita spending on children and families in managed care is significantly lower than the PCPM for other populations. In 2004, the PCPM for adults with disabilities increased the most, i.e., eight percent, over the previous year. The PCPM for the elderly increased six percent from FY 2003 The PCPM for children with special health care needs increased only one percent.

EXHIBIT 11

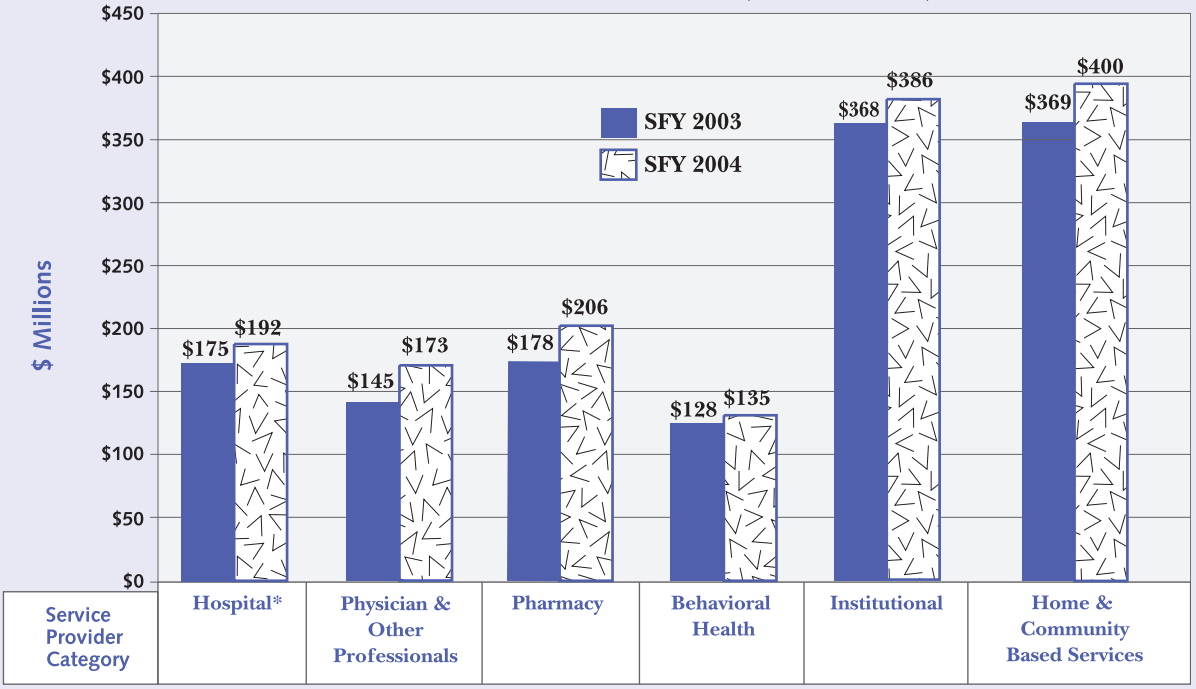
Rhode Island Medicaid Percent Program Expenditures vs Percent Caseload by Population Subgroup - FY 2004



* includes RIte Share
** includes children in foster care

EXHIBIT 12

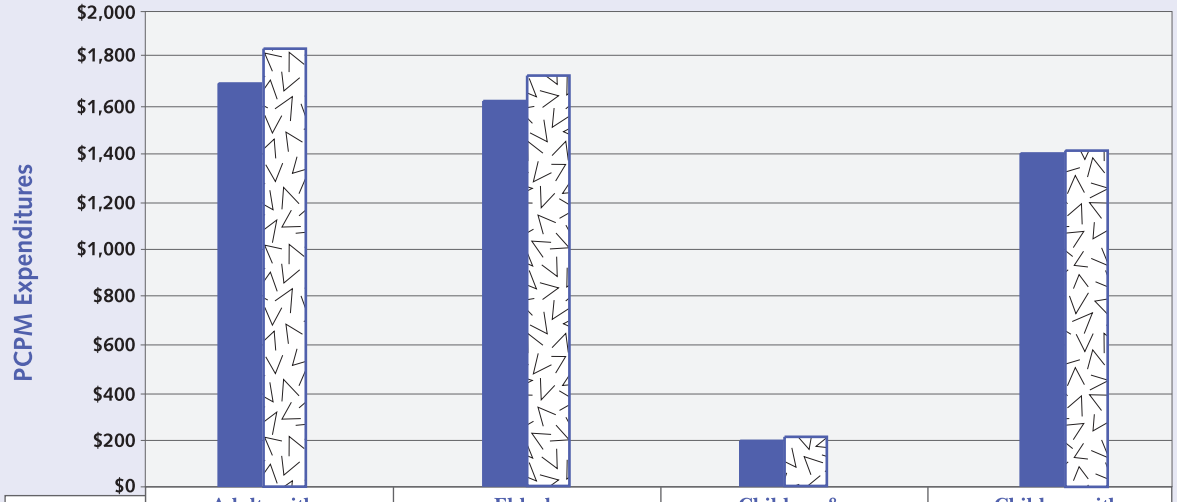
Rhode Island Medicaid Program Expenditures**
by Service Provider Category
FY 2003 and FY 2004 ($ in Millions)



*excludes disproportionate share payments
**excludes RIte Share

EXHIBIT 13

Rhode Island Medicaid Per Capita Per Month (PCPM) Program Expenditures
by Population Subgroup – FY 2003 and FY 2004



*excludes RIte Share

CENTER FOR ADULT HEALTH

PROGRAMS & INITIATIVES

WAIVER PROGRAMS

Most of the adults with disabilities and elderly adults enrolled in Medicaid receive services through the traditional Medicaid program. In addition, some individuals participate in one of Rhode Island's six home and community based services (HCBS) waiver programs. Waiver program participants receive home and community based services along with the full range of traditional Medicaid services.

The Department of Human Services (DHS) administers the **Aged and Disabled** waiver program. Enrolled individuals are eligible for case management, personal care, environmental modifications, special medical equipment, Meals-on-Wheels, senior companion and emergency response services. The waiver was initially approved in 1983 and is approved through 2008. In fiscal year 2004, 1,728 individuals received services through the Aged and Disabled waiver program.

The **Physically Disabled** waiver is administered through a partnership between DHS and the People Actively Reaching Independence (PARI) Independent Living Center. Independent living agencies provide case management and personal care services for individuals with quadriparesis or functional hemiparesis. Participants may receive case management, a personal care attendant, consumer preparation, environmental modifications, special medical equipment, homemaker services and emergency response services. Eighty-four individuals received services through this waiver in FY 2004. The waiver began in 1988 and is approved through 2009.

The **Assisted Living** waiver is a collaborative effort of DHS and the Department of Elderly Affairs and provides services to some individuals residing in certain assisted living facilities. The waiver funds case management, assisted living and special medical equipment for eligible individuals. The waiver began in 1999 and is approved through 2007. This waiver served 253 people in FY 2004.

The DHS and the Department of Mental Health, Retardation and Hospitals (MHRH) administer the **Mentally Retarded, Developmentally Disabled** waiver. Services funded under this waiver include case management, specialized homemaker, adult foster care, homemaker, respite, environmental modifications, special medical equipment, residential habilitation, day habilitation and supported employment. In FY 2004, 2,684 persons received waiver services. This waiver program was initiated in 1983 and is approved through 2006.

The DHS and Department of Elderly Affairs (DEA) administer a waiver for **Community Based Elderly** Medicaid recipients. Eligible individuals must be over age 65, and can receive case management, homemaker, personal care, Meals-on-Wheels, senior companion, environmental modifications and special medical equipment. In FY 2004, 607 Rhode Islanders received services under this waiver. The waiver began in 1988 and is approved through 2006.

The Habilitation waiver is administered through a partnership between the Department of Human Services (DHS) and the People Actively Reaching Independence (PARI) Independent Living Center. The independent living agency provides case management and works with MHRH certified providers and licensed home health agencies to arrange for needed residential and day habilitation services, private duty nursing, personal care, supported employment, special medical equipment, minor home modifications, personal emergency response units and community-based rehabilitation services. The waiver began in 2001 and is approved through 2009. Twenty-three people received these waiver services in FY 2004.

TBI IMPLEMENTATION GRANT

In March 2002, the US Department of Health and Human Services, Health Resources and Services Administration (HRSA) awarded a three-year, $600,000 Traumatic Brain Injury (TBI) Implementation Grant to the DHS Center for Adult Health. The successful completion of the Rhode Island Plan for TBI Services under the DHS 2000 HRSA TBI Planning Grant led to this proposal and subsequent award.

Highlights of the project for FY 2004 include:

- Completion of a "Brain Injury 101" Training video for service providers
- Completion of a statewide Resource Guide that includes brain injury specific and general disability/elder/child resources, disseminated to over 3,000 people statewide
- Over 18,000 multi-language fact sheets and concussion cards were distributed statewide
- Annual conference for survivors, families and professionals in March 2004 had over 200 participants, and
- Multiple educational presentations and media broadcasts were conducted statewide

The Brain Injury Association of Rhode Island is under contract with the DHS Center for Adult Health to conduct grant activities.

SYSTEMS CHANGE GRANTS FOR COMMUNITY LIVING

Real Choice Systems Change Grant

In fiscal year 2002, CMS provided the state with a Real Choice Systems Change grant aimed at building an infrastructure to support and sustain adult populations living in the community. (see Children with Special Health Care Needs for information on an additional grant.) Funded at $1.385 million over three years, the grant will: expand capacity to needed services; increase informed choices for consumers; and improve the integration of health and social services. The grant will be used to develop a web-based benefits screener and resource directory, develop service-tracking software, host a conference on community based services, conduct a needs-assessment survey of long-term care consumers, analyze Medicare data to identify patterns of individuals likely to become dually Medicare/Medicaid eligible, provide behavioral health consultation to non-institutional residences, track and analyze residential and community-based systems of care, and improve the transition for youth with serious emotional disturbances who transition to the community.

Nursing Facility Transitions Grant

The nursing facility transition grant was awarded in October 2002 by the Centers for Medicare and Medicaid Services. The goals of the grant are to provide institutionalized persons with information on community service options, help interested persons transition to a community living arrangement with necessary supports, and enhance the capacity of the home and community based system to serve individuals with multiple and/or complex needs.

ADULT HEALTH PROGRAMS & INITIATIVES - CONTINUED

In FY 2004, there were 124 new referrals to the program and 156 persons actually discharged from institutional settings. The program provided household furnishings for seventy-two people, and transitional assistance services for all persons referred. The major barrier for many of those still waiting to transition is the difficulty finding affordable accessible housing. A Request for Proposals was posted in December 2004 in order to start a day program for Rhode Islanders with significant cognitive disability. The start up funds for this day program will be paid with grant funds.

CASH & COUNSELING GRANT

In October 2004, the DHS was awarded $250,000 from the Robert Wood Johnson Foundation that will be fully matched with federal Medicaid dollars in order to develop a Cash and Counseling Program in Rhode Island. Cash and Counseling is a service delivery alternative in which people eligible for home and community-based support services can be allocated a budget equivalent to what would be otherwise spent. The consumer can then work with a counselor to develop a spending plan to meet their community-based support needs in a more flexible manner. Usually this includes individually hired personal assistance workers, shopping, homemaking and chore assistance. Cash and Counseling was pioneered in three states (Arkansas, New Jersey and Florida) through a demonstration and evaluation project. The program was found to result in much higher levels of satisfaction, fewer institutionalizations, improved or equivalent health outcomes, and no increased adverse incidents over those individuals served through a more traditional health system.

The first year of this grant will be to fully develop credentialing and oversight for counseling and fiscal intermediary services, set up information systems for incident reporting, worker recruitment and data collection, and convert the Severely Disabled Waiver over to a full Cash and Counseling Program. Initial enrollees will include adults with disabilities and elders.

PACE GRANT

PACE (Program for All-Inclusive Care for the Elderly) Programs coordinate and provide comprehensive, primary, specialty, and preventative medical care, as well as community support and social services enabling older individuals to continue residing in the community. PACE is an innovative model that enables individuals who are 55 years or older and certified to need nursing home care to live as independently as possible. The PACE program integrates both service delivery and reimbursement.

Over the last year the Department of Human Services in collaboration with the Department of Elderly Affairs and the University of Rhode Island has been working with CareLink, a non profit management service organization to establish a PACE Program in Rhode Island. These efforts have resulted in CareLink establishing PACE Organization of Rhode Island, a non profit entity that will manage and operate a PACE site in Rhode Island. A formal application has been submitted to the Centers for Medicare and Medicaid Services to establish the PACE Organization of Rhode Island as Rhode Island's first PACE provider. The PACE Program is expected to enroll beneficiaries starting July 1, 2005.

ADULT HEALTH PROGRAMS & INITIATIVES - CONTINUED

LONG TERM CARE INITIATIVE

State policy makers have long expressed concern about the escalating cost of and increasing demand for high-quality long-term care services for elderly individuals and those with chronic disabilities. Recently, financial pressures, workforce shortages, nursing home quality concerns and the state's aging population, among other issues, have heightened concern about the capacity and fiscal viability of the state's long term care system.

On October 3, 2003, Governor Donald L. Carcieri signed Executive Order 03-15 establishing the Governor's Cabinet on Chronic and Long Term Care to better coordinate state-administered programs supporting the needs of Rhode Island's seniors and adults with chronic conditions or disabilities. Modeled on the RI Children's Cabinet, the Chronic and Long Term Care Cabinet brings together key department directors to continue the discussions held as part of the Living Rite initiative and further consider a wide range of issues, including the implications of increased demand for services, the availability of providers, the quality of services furnished, and the effectiveness and efficiency of current delivery systems.

BREAST & CERVICAL CANCER PROGRAM

Taking advantage of a federal coverage option, the Department of Human Services and Department of Health in concert with representatives of women's cancer organizations designed and implemented a program to allow women with breast or cervical cancer or pre-cancerous symptoms to gain Medicaid eligibility. To be eligible a woman must be screened by the DOH-administered Women's Cancer Screening Program. The screening program is funded by the Federal Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program. The screening program provides no-cost pelvic exams, Pap tests, clinical breast exams, and mammograms to uninsured, low-income women.

Any woman screened by a provider who participates in the program and found to have cancer or pre-cancerous symptoms can enroll in Medicaid for the duration of her treatment. Although eligibility for coverage is based on the woman's need for cancer-related treatment, enrolled women are eligible to receive the full scope of Medicaid services.

Coverage was provided to 140 new participants during fiscal year 2004. Of the total, forty-two (42) had either breast or cervical cancer and ninety-eight (98) were eligible due to a pre-cancerous condition. A woman is eligible for coverage under this program until one of the following occurs: her course of treatment for breast or cervical cancer ends; she turns 65; she gains creditable coverage; she fails to complete a scheduled redetermination; or she is no longer a Rhode Island resident. Since its inception in April 2001, five hundred (500) women have benefited from this program. Currently there are 216 women actively enrolled.

ADULT HEALTH PROGRAMS & INITIATIVES - CONTINUED

CHRONIC CARE PROGRAMS

Connect CARRE

Connect CARRE is a care management and wellness program that provides comprehensive services to consumers with declining health and frequent illnesses. The program involves ongoing analysis of service utilization patterns for health indicator screenings and chronic care and disease management.

Participants in Connect CARRE are at risk for recurrent adverse medical events that lead to frequent hospitalizations and emergency room visits. Participants live in community settings but often lack social and community supports.

Connect CARRE links consumers to a medical home and a team of providers and care coordinators, including a Lead Physician and a Nurse Care Manager. The program helps consumers develop more consistent and supportive relationships with their health care providers, assists consumers and their families to manage chronic illness through educational programs, and identifies and coordinates services and care in the community in order to help consumers maintain wellness and reduce recurrent illness.

The program utilizes a care management model and includes disease management principles that support physician practice. Connect CARRE's consumer focused model provides enhanced benefits and utilizes health outcomes as program measures. Based on an initial consumer needs assessment, the clinical team (nurse care manager, assistant medical director, pharmacist and social worker) develops a care plan. The Nurse Care Manager coordinates care management and services along the continuum. In addition to improving participant wellness, Connect CARRE strives to maintain or improve the individual's functional status, increases his or her ability to manage their care, and decreases preventable hospitalizations and emergency department use. The program helps DHS identify gaps in the current delivery system and increase capacity to meet the needs of the target population.

Connect CARRE Program has enrolled 388 members through December 2004. Currently the program has 210 active enrollees. Preliminary program analysis has shown a significant decrease in inpatient admissions and an increase in home care services and pharmacy. The program continues to provide clinical and social support to its members as well as supporting the practice of its participating physicians.

Connect CARRE expects to continue active recruiting for new members in FY 2005, until a continuous enrollment of 300 members is reached. Also, the Center for Adult Health is researching opportunities to expand this program to reach a broader group of Adult fee-for-service Medicaid recipients who would benefit from additional community based clinical and social supports.

Department of Health Ocean State Immunization Coalition for Flu and Pneumonia Immunization in Community

The Ocean State Adult Immunization Coalition is a joint effort led by DOH, and includes DHS, Rhode Island Quality Partners, long-term care and home care agencies and the Visiting Nurses Association. The group is working to improve flu and pneumonia immunization rates for the over-65 and high-risk under-65 populations. This year the group made significant outreach to employer groups to improve immunization rates in the work force, in particular those agencies that provide adult and child day care.

ADULT HEALTH PROGRAMS & INITIATIVES - CONTINUED

Fall Prevention Forums

The Center for Adult Health sponsored the second "Best Practices" Forum for the Home Health Agencies on December 4, 2003. The focus of the forum was to provide agencies with a brief overview of successful Certified Nurses Assistant training programs on "Fall Prevention". The department identified agencies that provided training in this area that was comprehensive, and supported the department's goal of identifying opportunities in the community to decrease falls in the elderly. Two agencies were then invited to present their "Best Practices" to other home nursing agencies. The presenting agencies participate in the DHS Enhanced Reimbursement Program and must meet the strict requirements for the Staff Education Training. The evaluations indicated that the presentations were an excellent source of information, and were well received by the audience representing over 26 Home Health Care agencies.

Enhanced Home Health Agency Reimbursement Program

The purpose of the enhanced reimbursement program is to provide additional reimbursement when standards beyond minimal licensing requirements are met. Agencies are encouraged to apply for the enhanced reimbursement program and technical assistance is provided to help them improve performance and meet the enhanced standards. The number of Home Health Agencies that participate in this program was increased in 2004.

Current Status

- 46 of 58 Licensed Home Care Agencies have applied for and receive enhanced rates
- 40 Home Care Agencies participate in Staff Education to improve worker and client satisfaction
- 38 Home Care Agencies have achieved accreditation status
- 25 Home Care Agencies have achieved national accreditation
- 13 Home Care Agencies have achieved state accreditation
- 2 Home Care Agencies receive auto enhancements only
- 12 Home Care Agencies do not participate in this program
- DHS provides Technical Assistance to Home Care Agencies to assist agencies in performance improvement

DRUG UTILIZATION REVIEW

The Drug Utilization Review (DUR) Board oversees pharmaceutical use in Medicaid, in order to ensure that medications are utilized appropriately and cost-effectively. The Board is made up of physicians, pharmacists, and other health care professionals working in Rhode Island. The Board meets quarterly. In addition, DHS conducts prospective reviews through online edits and audits and in-pharmacy discussions with patients to ensure that duplicate or interacting medications are not prescribed. Health Information Designs, a contractor, conducts retrospective utilization review for Medicaid-payable prescription drugs, tracks trends in prescriptions, and provides information to help physicians improve their prescribing practices.

MEDICAL TRANSPORTATION

Many elderly citizens and people with disabilities receiving Medical Assistance need assistance with transportation to access medical services. Individuals are encouraged to seek help from friends, neighbors and families members. In addition, many health centers, community agencies and volunteer groups provide rides. When none of these are available, the state can provide assistance.

The Rhode Island Public Transportation Authority (RIPTA) provides "no fare" and free ride programs to Medical Assistance enrollees who apply for a RIPTA Senior/Disabled Bus Pass. The RIDE Program provides door-to-door transportation to medical appointments to people over age 60 and individuals with disabilities. Appointments require prior approval and must be made two weeks in advance of the date the transportation is needed.

CENTER FOR ADULT HEALTH

POPULATIONS & SERVICE EXPENDITURES

ADULTS WITH DISABILITIES

Population Characteristics

Medicaid's average monthly caseload of adults with disabilities (age 21 to 64) was 25,330 in fiscal year 2004. This is less than one percent increase from the previous year. By disability, disease or illness, adult Medicaid enrollees with disabilities fell into one of three population groups:

- Individuals with developmental disabilities, and
- Individuals who are physically disabled and/or mental retardation; chronically ill, and
- Individuals who are severely and persistently mentally ill

These three groups have different health care needs, and, depending on each individual's need for care, services are provided in the community, in a nursing home or other residential facility.

Services and Expenditures

In FY 2004, Medicaid spent $557 million on services for adults with disabilities, an 11 percent increase over the previous year. The average per client per month spending (PCPM) was $1,693. **Exhibit 14** shows the average monthly per-client Medicaid spending in these categories in fiscal years 2003 and 2004:

The average monthly expenditures per client grew eight percent between fiscal year 2003 and 2004. Average monthly expenditures per client increased in every service provider category. Home and community-based services remained by far the largest expenditure category, accounting for more than twice the spending of the next highest category. For the first time, pharmacy expenditures surpassed institutional spending and became the second largest category. The three largest expenditure categories, accounting for over 70 percent of all expenditures, were as follows:

- $745 PCPM for home and community based
- $298 PCPM for pharmacy
- $277 PCPM for institutional-based services

ELDERLY ADULTS

Population Characteristics

In fiscal year 2004, the average monthly caseload of recipients age 65 and over was 19,665, a less than one percent increase over FY 2003. Ninety (90) percent of Medicaid-funded nursing home residents were over 65 in fiscal year 2004.

Services and Expenditures

In fiscal year 2004, Medicaid spent over $425 million on services for aged recipients, an increase of nine percent over FY 2003. Per **Exhibit 15**, fiscal year 2004 PCPM expenditures for elderly recipients totaled $1,725, a six percent increase. Approximately 70 percent of expenditures, or $1,213 PCPM, for elderly recipients were for institutional services. Monthly per member costs for prescription drugs, the second largest category of monthly expenditures for the elderly population, rose thirteen percent in fiscal year 2004. ▼

CENTER FOR ADULT HEALTH

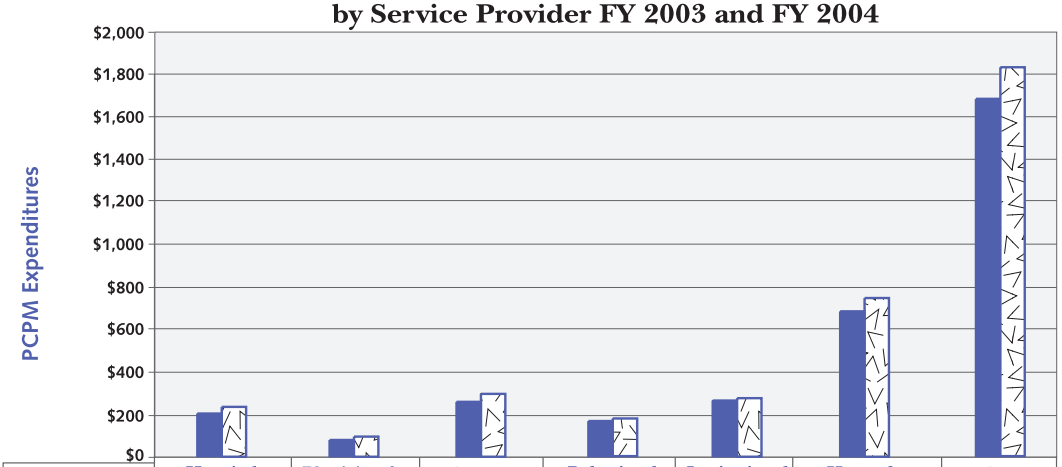
TRACKING ACCESS, QUALITY & OUTCOMES

The Research and Evaluation Project continued to investigate the health needs of Medicaid-eligible adults with disabilities. Over the past several years, evaluations have been performed to collect information on this population, through focus groups, a statewide survey and analysis of baseline and comparison years' utilization data.

Using these research methods, the Research and Evaluation Project has identified several consistent themes. To begin with, many Medicaid enrollees have multiple health problems. Often individuals suffer from both mental and physical conditions. Adult Medicaid recipients who live with disabilities and chronic conditions have complex needs for a wide spectrum of services. Evidence shows that many individuals have unmet needs for disease, treatment and care information, would benefit from stable connections with providers, and need assistance with their full range of medical, psychological and social services. The CAH is using these findings to identify ongoing client needs, develop programs and improve existing efforts, in order to improve access to and quality of care for program participants.▼

EXHIBIT 14

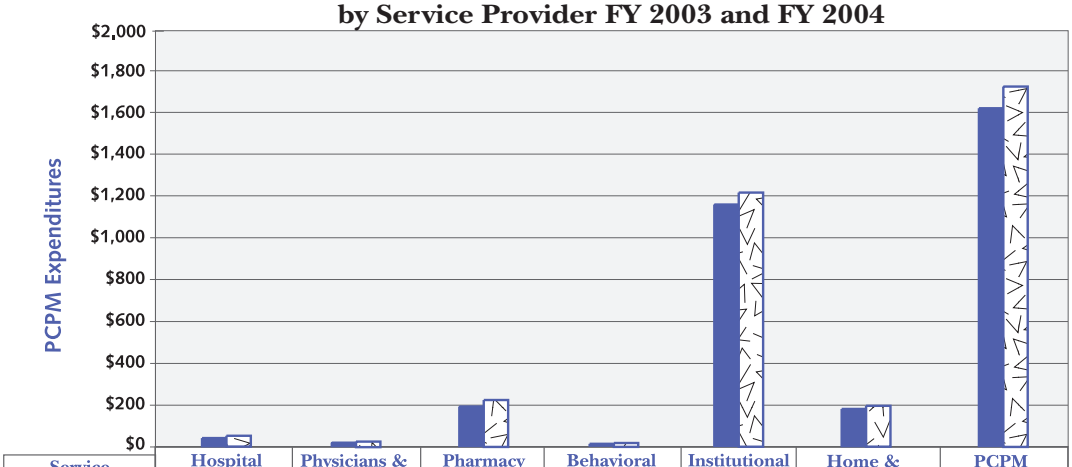
Adults with Disabilities PCPM Program Expenditures by Service Provider FY 2003 and FY 2004



Service Provider Category	Hospital	Physician & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services	PCPM
FY 2003	$203	$86	$263	$176	$272	$693	$1,693
FY 2004	$238	$94	$298	$182	$277	$745	$1,834

EXHIBIT 15

Elderly Adults PCPM Program Expenditures by Service Provider FY 2003 and FY 2004



Service Provider Category	Hospital	Physicians & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services	PCPM TOTAL
FY 2003	$48	$20	$199	$14	$1,161	$183	$1,624
FY 2004	$55	$21	$224	$14	$1,213	$199	$1,725

CENTER FOR CHILD & FAMILY HEALTH

PROGRAMS & INITIATIVES

INTRODUCTION

The Center for Child and Family Health (CCFH) administers the delivery of health services for the following Medicaid/SCHIP populations:

- Children under age 19 living in families with incomes less than 250 percent of FPL
- Pregnant women with incomes less than 250 percent of FPL
- Parents of children with family incomes less than 185 percent FPL
- Children with special health care needs, including those eligible for Medical Assistance due to:
  - Foster care (substitute placement) (up to age 21)
  - Subsidized adoptive placements (up to age 21)
  - Supplemental Security Income (SSI, up to age 21)
  - The Katie Beckett provision (up to age 18)

These populations receive health care services through either the RIte Care program or traditional fee-for-service Medicaid. Over the past two years, DHS has initiated strategies designed to stabilize growth in the RIte Care program, both by implementing RIte Share, Rhode Island's premium assistance program for employer-sponsored health care coverage, and through the implementation of cost-sharing for RIte Care and RIte Share families. In addition, since November 2000, the Department has worked to contain the growth in expenditures for services and enhance the quality, access and coordination of care for children with special health care needs by transitioning them into RIte Care. Beginning in 2001, the Department began operation of the CEDARR Initiative, a family-centered system of evaluation, care planning, family information and support and timely access to health services which augments the care of children with special health care needs.

RITE CARE FOR CHILDREN & FAMILIES

RIte Care is Rhode Island's Medicaid managed care program for low-income and uninsured children, parents, and pregnant women. RIte Care was implemented in 1994 under a Section 1115(a) Waiver. The Waiver allowed Rhode Island to create a comprehensive, coordinated health care delivery system through competitively procured contracts with licensed managed care organizations accredited by NCQA. RIte Care implementation changed the nature of the delivery system for Medicaid enrollees by enrolling members in a health plan, providing every member with his or her own primary physician and implementing standards for provider accessibility and responsiveness. A core goal was to increase access to appropriate, timely primary care, including preventive care and "sick visits", thus decreasing the reliance on less appropriate emergency department visits and reducing avoidable hospitalizations.

RIte Care has increased enrollee access to health care and improved health outcomes, while containing the growth of costs. Not all managed care is alike: RIte Care has several key design features specified in the Health Plan contracts that are quite different from health plans' commercial contracts. These design features, along with oversight and monitoring by the State, are key ingredients in RIte Care's success. Evaluations of RIte Care have shown very significant improvements in participants' access to timely primary care as well as specialty care. Choice has been expanded by providing access to a much wider network of primary care and specialist providers than had been

available in fee-for-service Medicaid. Overall, 97 percent of enrollees indicate that they are very satisfied or satisfied with RIte Care - a percentage that has remained relatively consistent for the past five years.

RIte Care has had a significant impact on the uninsured in Rhode Island. At its inception, 11.5 percent of the total population and 9 percent of children were uninsured. In 2000, the uninsured population in Rhode Island had dropped to 6.2 percent and 2.4 percent, respectively, the lowest in the nation. Unfortunately, Rhode Island's uninsured population increased to 10.2 percent of the total population and 5.2 percent of children, in 2003, largely as a result of the reduction in employer-sponsored health care coverage. Despite this concerning increase, Rhode Island still has one of the lowest percentages of uninsured in the nation.

As of June 30, 2004, 124,921 individuals were enrolled in RIte Care. This total includes 2,102 children in substitute care (formerly referred to as children in foster care) and 3,540 children with special health care needs who were enrolled in NHPRI. Health Plan enrollment as of that date was distributed as follows:

- NHPRI: 72,994
- United: 39,147
- Blue Chip 12,780

The above numbers are based on enrollment at a "point in time," thus they vary from the average monthly caseload figures that are reported elsewhere in this document.

RIte Share for Children and Families

The RIte Care Stabilization Act of 2000 established the RIte Share program, a combined Medicaid/SCHIP premium assistance program intended to support families in their efforts to obtain or maintain private, employer-sponsored health insurance. RIte Share pays (all or part of) an eligible families employer-based health insurance cost, as long as that cost is less than a family's cost of coverage under RIte Care, in other words, if it is more "cost-effective" for the State to pay the employee's share of the employer-sponsored premium than to pay the RIte Care premium. Enrollment in RIte Share is mandatory for Medicaid-eligible individuals whose employer offers an approved health plan. Enrollment of both employees and employers in the RIte Share program has continued to grow. As of January 2002, 117 employers were approved for participation in RIte Share. As of December 2004, 1060 employers were approved for participation in RIte Share.

Since the program started, DHS has been transitioning RIte Care members into RIte Share. At the time RIte Share became mandatory, DHS estimated that there were 7,000 workers, employed by 4,500 companies, who were eligible to be transitioned to RIte Share. However, not all workers are eligible for commercial health insurance through their employers because of, for example, part-time employment or probationary periods.

In order to transition a RIte Care member to RIte Share, employers must provide DHS with information about their health insurance plan and employee contributions. Changes in the commercial health insurance market present additional challenges to RIte Share. For example, more and more employers are adopting health plans with front-end deductibles and greater differentials in coverage levels for in-network benefits. An employer can mitigate large rate increases through the magnitude of deductibles. For example, a $200 deductible could reduce the premium rate by, say, 3 to 4 percent, whereas, a $750 deductible could reduce the premium rate by, say, 9 or 10 percent. While plan design changes can mitigate the cost of commercial coverage to a certain extent, the cost of coverage may still prove to be too much for employers (and employees) particularly in a "down economy".

As of June 2004, 5,127 individuals were enrolled in RIte Share. At the current level of effort and given the limitations of needed information received from members and employees about available coverage, DHS can transition between 150 to 200 RIte Care members to RIte Share each month. In total, RIte Share saved an estimated $3.7 million ($1.4 million State) in SFY2004.

COST-SHARING FOR CHILDREN & FAMILIES

The RIte Care Stabilization Act of 2000 also mandated cost-sharing for RIte Care and RIte Share families with family income above 150 percent of the FPL ($23,505 for a family of three). As of August 1, 2002, state law mandated that cost-sharing be raised to approximately five percent of FPL. This amount ranges from about $61 to $92 per month.

Monthly premiums are collected in two ways:

- For RIte Care, DHS sends a bill and the family pays DHS directly by mailing a check.
- For RIte Share, DHS deducts the monthly premium from the amount it reimburses the member for the employee's share of employer coverage.

As of December 2004, 5409 families (13,611 individuals) were subject to cost-sharing or about 10 percent of all RIte Care and RIte Share enrollees. Any family who is two months in arrears is disenrolled from coverage and can not re-enroll for four months. An average of 150 families a month are sanctioned for failure to pay premiums. In total, $3.28 million ($1.2 State) were collected from family cost sharing in SFY 2004.

IMPACT OF RITE SHARE & COST SHARING ON RITE CARE

In SFY 2004, combined RIte Care and RIte Share enrollment growth averaged 277 individuals per month. This reflects a continued reduction in the rate of growth when compared to previous years:

- In FY 2000, RIte Care enrollment growth averaged 1,452 per month. This was during the time of crisis in Rhode Island's health insurance market, discussed earlier in this report.
- In FY 2003 and FY 2004, RIte Care and RIte Share enrollment growth averaged 404 and 308 per month, respectively.

The implementation of RIte Share and cost-sharing has achieved its intended purpose of stabilizing growth and expenditures of RIte Care.

TRANSITIONING CHILDREN WITH SPECIAL HEALTH CARE NEEDS INTO RITE CARE

Children in Foster Care

In FY 2001, RIte Care began enrolling children in foster care (also referred to as children in substitute placement). Children in foster care are categorically eligible for Medicaid, but had remained in fee-for-service because of concerns about how managed care would address their needs. Historically, 70% of foster care children had previously been RIte Care members. In preparation for the RIte Care enrollment of children in foster care, the Department of Children, Youth and Families (DCYF) and DHS established governing principles for the partnership and invited Health Plans to participate. Currently, only NHPRI enrolls children in foster care.

The partnership between DHS, DCYF and NHPRI facilitated several system changes. The behavioral health provider network available to children in foster care was substantially strengthened by including all DCYF active and specialty behavioral health providers in the NHPRI behavioral health provider network. The DCYF and NHPRI have developed a capability that enables data exchange on a daily basis. This exchange provides NHPRI with current placement information on these children and gives DCYF the name of each child's current primary care provider.

As of July 2004, 2,102 children in foster care were enrolled in RIte Care.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

Children in SSI, Katie Beckett and subsidized adoptive placements

During SFY 2004, an average monthly caseload of 9,793 children with special health care needs (CSHCN) including children in Supplemental Security Income (SSI), Katie Beckett and subsidized adoptive placements, received health care through Rhode Island Medicaid on a fee-for-service basis. Almost two-thirds of these children qualified for Medicaid due to SSI eligibility, which is based on the family's income and the child's health status. An additional 12% of these Medicaid-eligible children with special health care needs qualified under the "Katie Beckett" provision, where eligibility is based upon the child's (not the parents') income and resources and the determination that the child needs an institutional level of care and the cost caring for the child at home is less than the cost of care in an institution. The remainder of the non-RIte Care enrolled children with special health care needs were Medicaid-eligible by virtue of their qualification under Rhode Island's adoption subsidy program.

A Governor's budget initiative in FY 2003 directed DHS to design a service delivery strategy that would allow Medicaid eligible children with special health care needs to be enrolled in RIte Care and have their routine and specialized health care needs met through the participating health plans.

Based on the successful enrollment of foster children, the State believed children with special health care needs could benefit from improved access to care and care coordination afforded through RIte Care by utilizing a service delivery strategy focused on the children's unique needs, the strengths of the family and coordination of services. Enrollment in RIte Care expands provider availability and access to quality, timely provision of services. Slowing the rate of cost increases is an anticipated by-product of improved care.

Families of CSHCN can voluntarily enroll their Medicaid eligible child in RIte Care through Neighborhood Health Plan of Rhode Island (NHPRI). DHS requires that NHPRI maintain a specialized care management program for these children. Enrollment commenced in September 2003. Enrollment in NHPRI is available to those children who do not have other commercial (third party) health insurance.

In SFY 2004, an average monthly caseload of 2,061 children in SSI or Katie Beckett and children in subsidized adoption were voluntarily enrolled in RIte Care by their families. Of those families offered enrollment in NHPRI, approximately 72% chose to enroll their child. In other states, voluntarily enrollments yielded only a 20-30% participation rate. In Rhode Island, families have expressed significant satisfaction with NHPRI's care management program as well as the robust provider network, which provides enhanced access to primary and specialty care providers. CSHCN also have access to RIte Care "Out of Plan" services which are provided on a fee for service basis. Examples of "Out of Plan" services include CEDARR Family Centers, CEDARR direct services and dental care.

CEDARR FAMILY CENTERS

The CEDARR Family Center (CFC) serves as a family-centered source of information, clinical expertise, connection to community supports and assistance to aid the family in meeting the needs of Children with Special Health Care Needs (CSHSN). CEDARR stands for: Comprehensive Evaluation, Diagnosis, Assessment, Referral and Re-evaluation. The CEDARR initiative links families to services across public programs and community supports based on a comprehensive assessment of the child and family's needs.

The Leadership Roundtable on children with special health care needs adopted a statewide vision in 1999, which states, "All Rhode Island Children and their families have an evolving, family-centered strength-based system of care, dedicated to excellence, so they can reach their full potential and thrive in their own communities." The outcome of this was a plan in the year 2000 to develop and establish the CEDARR Family Centers, the first of which opened its doors in April 2001.

Services provided through the CEDARR Family Center are designed to identify the appropriateness of care, support a more family-centered system of care, maintain clinical excellence, improve outcomes, and promote overall cost effectiveness for Medicaid-eligible children with special health care needs. In addition, the CEDARR initiative established the means to support new and expanded services in critical areas that currently do not exist or are limited. These services are referred to as CEDARR direct services.

The CEDARR Family Center provides both basic services and supports to families, access to specialized clinical evaluations, and coordination of services. The CEDARR Family Center will work with the child and family to assess current circumstances and identify with the family community services and supports that will assist the family in supporting their child with special health care needs in the home and community.

A Family Care Plan may be developed for some families and could include CEDARR direct support and enhanced services. The CEDARR Family Center will make referrals for all services and supports determined to be necessary for the child and family, and will help coordinate arrangements for CEDARR direct services. Family Care Coordination assists the family in accessing appropriate services.

In FY 2004, three CEDARR Family Centers were in operation around the state. The CEDARR Family Centers assisted 829 children and their families. Of the children accessing a CEDARR Family Center in FY 2004, 559 (67%) were male, and 402 (49%) were under age 8 at first contact. CEDARR Family Centers served children and families from 39 cities and towns in Rhode Island.

One of the key responsibilities of the CEDARR Family Center is to identify gaps in the current array of services available to meet children's and families' needs, as well as to identify capacity shortfalls. When fully implemented, CEDARR direct services will improve access to a wider continuum of care for children with special care needs. The following CEDARR direct services are being made available when included in a CEDARR Family Care Plan.

CEDARR Direct Services

Home Based Therapeutic Services

Since the mid-1990's, Medicaid eligible children with special health care needs have been receiving Home - Based Therapeutic Services (HBTS) under the provisions of Early Periodic Screening, Diagnosis and Treatment. In February of 2003, the Department of Human Services (DHS) issued certification standards for provider agencies of home-based services. Currently, there are 14 certified HBTS provider-agencies across the state. DHS continues to maintain an open application process for any interested party wishing to become certified as an HBTS provider-agency.

HBTS represents an array of therapeutic services designed to reduce and/or ameliorate deficits in cognitive, communication, psychosocial, and physical functioning in children with special health care needs. This therapeutic service is intended to maintain, stabilize and/or improve adaptive functioning of these children. HBTS is often indicated because children diagnosed with moderate to severe physical, developmental, behavioral or emotional conditions require health and related services beyond those required by children generally.

HBTS is unique in that services are provided in children's homes and community settings by paraprofessionals under the direction of licensed health care professionals. Treatment is therapeutically based upon identification of treatment objectives, specified methods of intervention, and measurable objectives. Participation of parents or caregivers is required. HBTS provider-agencies are an important resource for CEDARR Family Centers. Typically, families are referred to HBTS following a CEDARR Family Center assessment and treatment recommendation.

Over the past year, HBTS provider agencies have served about 416 children. The maximum hours of HBTS authorized each week cannot exceed forty hours per client. The average client received seventeen hours of HBTS services per week. A treatment plan lasts for 6 months and can be renewed as necessary.

The age distribution of children receiving HBTS have remained relatively constant over the years. Utilization of children by age group for the past year was as follows: 0 - 4 years old represent 8%; 5 - 9 years old represent 35%; 10 - 14 years old represent 42%; and 15 - 19 years old represent 15% of the caseload. Their special health care needs were as follows: 11% have medical/physical conditions; 7% have developmental conditions; 52% have behavioral health conditions; and 30% have autism spectrum conditions.

Therapeutic Child and Youth Care

Therapeutic Child and Youth Care provides Medicaid funding for specialized therapeutic supports to allow children with significant physical, developmental, behavioral or emotional conditions to participate in typical child and youth care settings. This program features an "inclusive" model, allowing children with special needs to participate in child and youth care settings with peers who are typically developing.

DHS released certification standards for its Therapeutic Child and Youth Care Program in spring of 2003. Two providers have been certified and DHS is recruiting additional providers in 2005. The DHS goal is for Therapeutic Child and Youth Care to be available on a statewide basis for all Medicaid-eligible children and families needing this service.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

EARLY INTERVENTION

Budget Article 44, effective July 1, 2004, transferred the administration of the State's Early Intervention (EI) System from the Rhode Island Department of Health (HEALTH) to the Rhode Island Department of Human Services (DHS). The transition was officially complete as of January 2005. The Departments of Health and Human Services made a commitment to work together to ensure that there were no disruptions to any child's service. DHS has taken many actions to ensure that the process went as smoothly as possible, including informational mailings to EI families and other stakeholders, surveys, site visits, training and orientations and the transferring of three (3) HEALTH staff to DHS. Other efforts included meetings and communications with other stakeholders, surveys of families utilizing EI services, site visits to EI providers and technical assistant to ensure appropriate reimbursement to EI providers.

In addition to Article 44, an insurance mandate was passed in the SFY 2004 legislative session (Article 22). Article 22 mandated that all commercial insurers licensed in Rhode Island reimburse certified EI providers for all EI services provided to eligible children and families to a maximum of $5,000 per calendar year per child. Also mandated was that this benefit would not include co-payments or deductibles for families and would not be applied to any annual or lifetime maximum benefit contained in the policy or contract.

DHS will continue to ensure that quality services are provided to children and families in Rhode Island through Early Intervention providers throughout the state. This transition is an opportunity to strengthen a valuable service to children with special health care needs.

SCHOOL-BASED HEALTH SERVICES

Approximately 50 percent of the children who receive special education services in Rhode Island are Medicaid eligible. All Rhode Island school districts are participating Medicaid providers. The DHS works with Local Education Agencies (LEAs) and the Department of Education to maximize local schools' ability to receive Medicaid funding for needed medical and dental care provided to Medicaid eligible students. In FY 2001, an administrative claiming program was implemented.

LEAD CENTERS

The Department monitors and oversees 4 Certified Lead Centers according to the certification standards developed in 1998 and revised and reissued in 2002. Certified Lead Centers assist families through intensive case management, coordination of housing inspections, relocation assistance, family education, training on cleaning techniques, referrals to medical, legal, nutritional, early intervention, special education, intensive environmental cleaning and other services. The Department reimburses for window replacement costs in the homes of RIte Care enrolled children with significant lead poisoning.

The four Certified Lead Centers are:

Blackstone Valley Community Action Program
32 Goff Avenue
Pawtucket, RI 02860

Family Services of RI
5 Hope Street
Providence RI 02906

West Bay Community Action Program
205 Buttonwoods Avenue
Providence, RI 02906

St. Joseph Hospital Lead Center
21Peace Street
5th Floor East
Providence, RI 02907

In FY 2004 the Lead Centers provided services to 62 children.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

DRUG COURT

The Rhode Island Family Court, Attorney General, Public Defender, DCYF, MHRH, DOH and DHS collaborated to plan and develop the Rhode Island Family and Juvenile Drug Court. The Juvenile Drug Court grew out of a recognized need for a therapeutic approach to nonviolent juveniles whose involvement in Family Court is attributable to their dependency upon alcohol and other drugs. In addition, there is evidence that a specialized court can enhance public safety by breaking the cycle of recidivism.

Juvenile Drug Court was launched in December 1999. In FY 2004, ninety-two (92) participants were admitted to the program. Seventy one (71) graduated during the year. Through a series of amended administrative orders, the program was expanded from Providence and Bristol Counties to cover juveniles living anywhere in Rhode Island.

RWJF STATE COVERAGE INITIATIVE PROJECT

In FY 2002, Rhode Island was one of only four states to receive a multi-year demonstration grant from the Robert Wood Johnson Foundation's State Coverage Initiative (SCI) Program. The SCI demonstration grants are targeted to states that are ready to achieve a sizable coverage objective, such as significantly reducing the number of working uninsured or designing a novel coverage model or partnership. Rhode Island's project is designed to reduce the level of uninsured in the state by fully implementing RIte Share. Major grant activities include: **(1)** conducting a formative evaluation of RIte Share operations to ensure that the program is designed to maximize enrollment and budgeted cost-savings, and using this evaluation to create a "how-to" manual for other states starting premium assistance programs; **(2)** developing and implementing a management information system for RIte Share that facilitates monitoring and continuous improvement in the areas of enrollment, cost-effectiveness and access to appropriate, effective health care services; **(3)** conducting, in partnership with the Department of Health, a statewide survey of patterns in employer health insurance to assess trends from a similar survey conducted in 1999 and to elicit feedback from employers concerning RIte Share; **(4)** conducting a study of the impact of "churning" (frequent change of coverage status) on access to care for Rhode Island's low-income working population; and **(5)** in partnership with the Brown Medical School, establishing a research fellowship that will facilitate the application of Brown's significant health services research capacity into Rhode Island Medicaid's design and evaluation.

PERSONAL ASSISTANCE SERVICES AND SUPPORTS (PASS) GRANT

In FY 2002, CMS awarded DHS and its partners a Community-Integrated Personal Assistance Services and Supports (PASS) grant. This grant supports the design and implementation of a consumer-directed program for children with special health care needs living in the community. The Center for Child and Family Health released certification standards for this program in August 2004. Applications from providers are under review. Once implemented, the PASS program will provide services and supports to allow children and youth with special health care needs to grow, develop and live as independently as possible in their homes and communities.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

RHODE ISLAND ORAL HEALTH ACCESS PROJECT

The Robert Wood Johnson Foundation awarded Rhode Island $940,000 for a three year period for the Rhode Island Oral Health Access Project. A portion of the funds are being used by the Department of Human Services, Center for Child and Family Health to restructure the Medicaid dental delivery system to improve access to dental care with emphasis on preventive and primary care, while containing the growth in costs to the current trend rate. This will allow DHS to transition from a payer of claims to a purchaser of dental services (through a competitive bid process) by contracting with a Dental Plan or Dental Benefits Manager (DBM) to administer the benefit. In collaboration with a DBM Workgroup, project management staff has made great strides toward this end and continues to work on drafting purchasing specifications, exploring viable benefit designs and once developed, pricing options.

The second component of the project included awarding RWJF grant funds totaling $737,308 to support increased access to dental care through fourteen programs at eleven RI organizations.This was accomplished through a unique partnership between the Rhode Island Department of Human Services, the Rhode Island Foundation, and Rhode Island KIDS COUNT. The projects, funded in 2004 focus on:

- Workforce Capacity Development,
- Safety Net Provider Service Capacity Development and
- School-Based Dental Services.

As the third project component, RI KIDS COUNT is managing public engagement efforts to keep the issue of access to oral health services in the forefront for policy makers and the public.

HRSA STATE PLANNING GRANT PROJECT

In October 2003, Rhode Island was awarded $961,156 in federal funds from the United States Department of Health and Human Services, Health Services and Resources Administration (HRSA) to develop a *Plan for Providing Access to Affordable Health Care Coverage for All Rhode Islanders.*

DHS is the State's lead agency for administering the project. The Project Management Team has built on the management structure of the Center for Family and Child Health and the project structure of Rhode Island's State Coverage Initiative (SCI) Project outlined above. The Project Director and Project Management Team Leader is the Administrator of the Center for Child and Family Health. Key staff from the Departments of Administration, Health and Business Regulation plus the Economic Development Corporation provide advice in their areas of expertise and collaborate as members of the team.

The Project is assessing national and Rhode Island-based research and policy analysis concerning the uninsured, the health care system, public and private health care coverage, and the health care marketplace and its regulation.

Experts were brought in to assist the Project in understanding the options fully and their potential for Rhode Island. Each option is being assessed as to its applicability and viability, with the ones holding the greatest promise being simulated to determine their potential cost. The need for State legislation, Medicaid State Plan amendments, and/or Federal Waivers will be explored as necessary mechanisms to implement options. The Project will submit a report to the Governor summarizing its work and the Governor will submit the required report to the Secretary of the U.S. Department of Health and Human Services by the end of the grant period. ▼

CHILD & FAMILY HEALTH

POPULATION & SERVICE EXPENDITURES

CHILDREN & FAMILIES IN MANAGED CARE

Population Characteristics

Rite Care - Children and Families

In FY 2004 children under age 18 accounted for 66 percent of the RIte Care average monthly caseload. Approximately three-quarters of the adults were female. Ninety-seven (97) percent of RIte Care members had household incomes below 185 percent of the federal poverty level (FPL), or below $28,990 for a family of three. Twenty-two (22) percent of the population spoke a language other than English as their primary language spoken at home. The second most common language, Spanish, was spoken by 18 percent of RIte Care members.

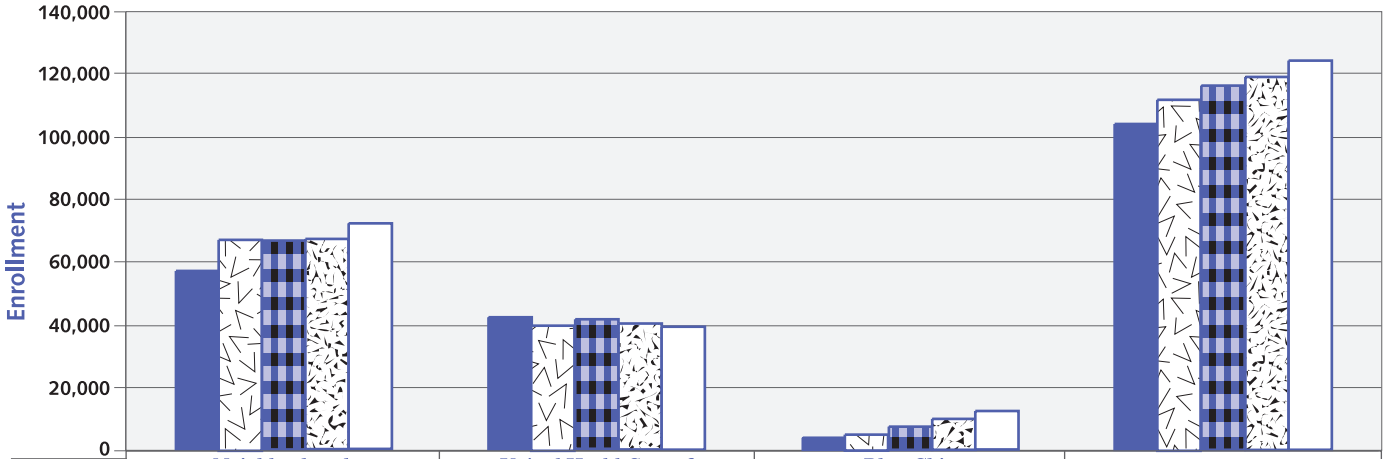
The distribution of RIte Care membership across the three participating health plans is displayed in **Exhibit 16**. At the end of the FY 2004, 58 percent of all RIte Care members were enrolled through NHPRI. United Healthcare and Blue CHiP had 31 percent and 10 percent of RIte Care members, respectively.

RIte Share - Children and Families

In FY 2004, RIte Share's average monthly caseload was 5,127. Sixty-four (64) percent of the caseload were children under age 18. Based on December 2004 data, of RIte Share's total enrollees:

- 33 percent were enrolled in Blue Cross/Blue Shield of RI's Healthmate product
- 32 percent were enrolled in United Health Care of New England
- 18 percent were enrolled in BlueChip
- 17 percent were enrolled in fifteen (15) other health care products

EXHIBIT 16
RIte Care Enrollment* by Health Plan
FY 2000 to 2004



Health Plan	Neighborhood Health Plan	United HealthCare of New England	Blue Chip	TOTAL
2000	57,315	42,747	4,381	104,443
2001	67,057	39,964	4,603	111,624
2002	67,410	41,900	7,714	117,024
2003	67,558	41,062	10,637	119,257
2004	72,994	39,147	12,780	124,921

*Point in time count by health plan & includes children with special health care needs enrolled in RIte Care beginning in 2002.

Exhibit 17 displays combined enrollment trends in RIte Care and RIte Share. Beginning in January 2002, RIte Care enrollment leveled-off as new applicants and existing RIte Care members with access to employer-sponsored health insurance were enrolled in their employer's coverage through RIte Share.

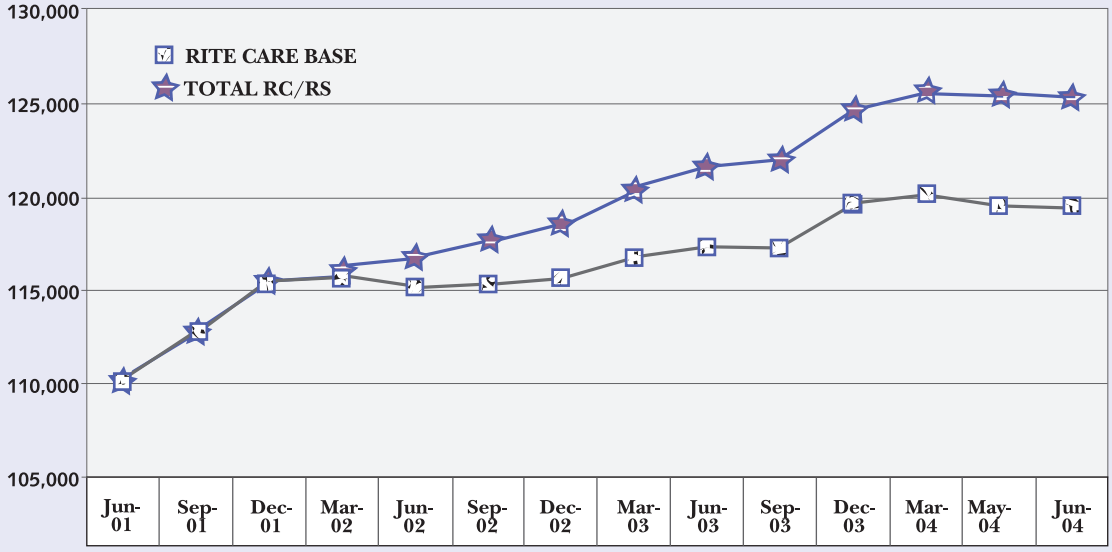
Services & Expenditures

Rite Care - Children and Families

In FY 2004, total Medicaid expenditures for RIte Care children and families (excluding RIte Share) were $309 million an increase of twelve percent over the previous year. Exhibit 18 displays FY 2004 average per client per month (PCPM) expenditures by service for children and families in managed care. The total PCPM includes services funded by DHS, DCYF and the LEAs for capitation payments to health plans, additional funds paid to health plans for services provided beyond the capitation package (such as unlimited mental health services), and funds paid directly to providers for services not provided by the health plans (including dental and transportation). Between FY 2003 and FY 2004, the total PCPM grew six percent to $206. The three largest expenditure categories, accounting for over 80 percent of all expenditures, were as follows:

- $78 PCPM for physician and other professional services (including outpatient hospital services)
- $61 PCPM for hospital services (including inpatient and emergency department services)
- $32 PCPM for pharmacy

EXHIBIT 17
RIte Care/RIte Share Enrollment Trends
June 2001 to June 2004



CHILD & FAMILY HEALTH POPULATION & SERVICE EXPENDITURES - CONTINUED

RIte Share - Children and Families

In FY 2004, total Medicaid expenditures for RIte Share children and families were $7.6 million, reflecting $5.9 million in premium payments to employer-sponsored health plans to pay the employee share of premiums and $1.7 million for Medicaid services not covered by employer-sponsored coverage. The total per client per month (PCPM) cost of RIte Share coverage was $119 distributed as follows:

- $98 PCPM for the employee's share of employer-sponsored health plan premium
- $21 PCPM for services not covered by the health plan premiums

CHILDREN WITH SPECIAL HEALTH CARE NEEDS - TOTAL POPULATION

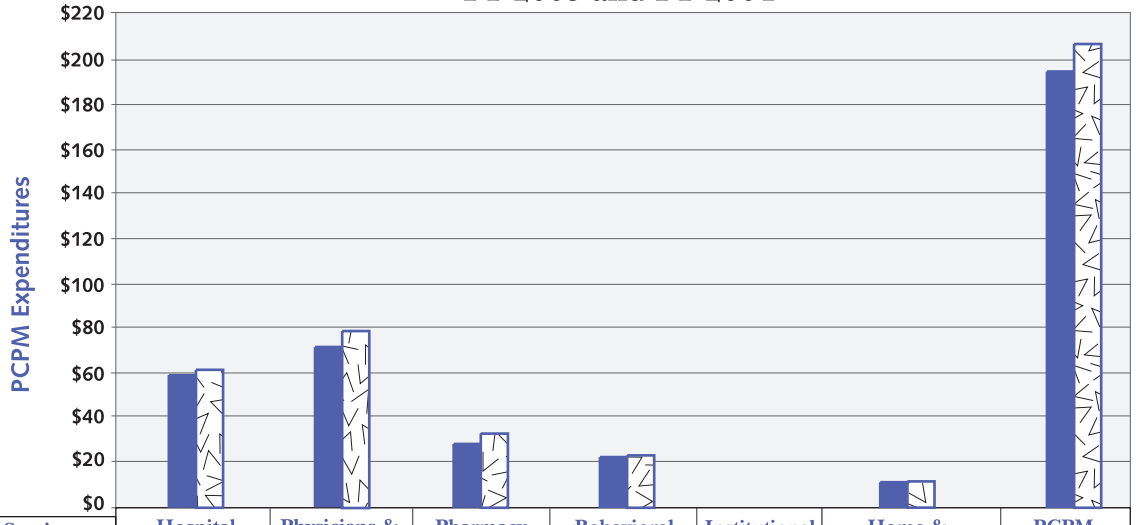
Population Characteristics

In the aggregate, an average of 13,869 children with special health care needs were served in Medicaid each month during FY 2004, an increase of 14 percent from the previous year. Children in this subgroup are eligible for Medicaid because they are enrolled in SSI, under the Katie Beckett provision, in adoption subsidy or in substitute placement (foster care).

Eligibility for SSI is based on family income and the child's health. Children with special health needs receiving an institutional level of care in the home who do not meet SSI financial eligibility requirements may be found Medicaid eligible if they meet the requirements of the Katie Beckett provision. "Katie Beckett" eligibility is based on: **(1)** the child's income and resources only (not the parents'); and **(2)** a calculation that the cost of caring for the child at home is less than the cost of care in an institution.

EXHIBIT 18

Children & Families in Managed Care*
PCPM Program Expenditures by Service Provider
FY 2003 and FY 2004



Service Provider Category	Hospital	Physicians & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services*	PCPM
SFY 2003	$60	$72	$29	$23	--	$11	$194
SFY 2004	$61	$78	$32	$23	--	$12	$206

*excludes RIte Share

CHILD & FAMILY HEALTH POPULATION & SERVICE EXPENDITURES - CONTINUED

Children are placed in substitute placement under the child protective services of the Department of Children, Youth and Families due to neglect and physical, sexual or emotional abuse. Children in substitute care, up to age 21, are eligible for Medicaid.

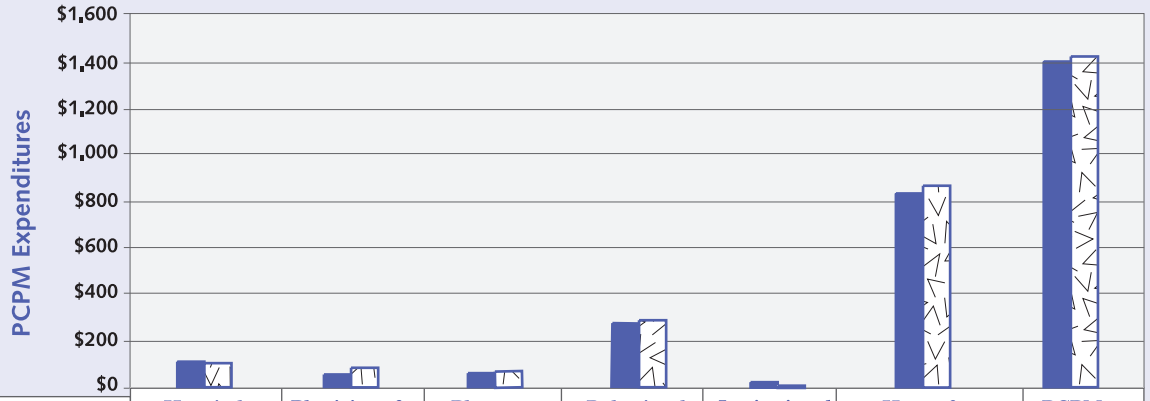
A third group of children with special health care needs is made up of individuals under age 21 who have been adopted through subsidized adoptive arrangements. The agreement between the state and the adoptive parents includes a provision indicating that the child will remain Medicaid eligible until he or she turns 21.

Services & Expenditures

Total Medicaid program expenditures for the aggregate population were $192 million, an increase of two percent from FY 2003 expenditures. The total per capita per month (PCPM) spending was $1,409. As displayed in **Exhibit 19,** two service provider categories represented over 80 percent of all expenditures, i.e.:

- $856 PCPM for home and community-based services (including EPSDT services, intensive home-based therapy, private duty nursing, and certified nursing assistant services)
- $289 PCPM for behavioral health services.

EXHIBIT 19
Children with Special Health Care Needs
PCPM Program Expenditures by Service Provider
FY 2003 and 2004



Service Provider Category	Hospital	Physicians & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services	PCPM
SFY 2003	$117	$57	$63	$282	$42	$834	$1,395
SFY 2004	$106	$85	$69	$289	$5	$856	$1,409

CHILDREN WITH SPECIAL HEALTH CARE NEEDS - SUBPOPULATIONS

Under RI General Laws Section 42.12.27, in SFY 2004, The Department of Human Services was instructed to report on expenditures on the following sub- populations within children with special health care needs:

- Children with disabilities (children with SSI or covered under the Katie Beckett provision
- Children in substitute care (formerly referred to as children in foster care)
- Children in subsidized adoption.

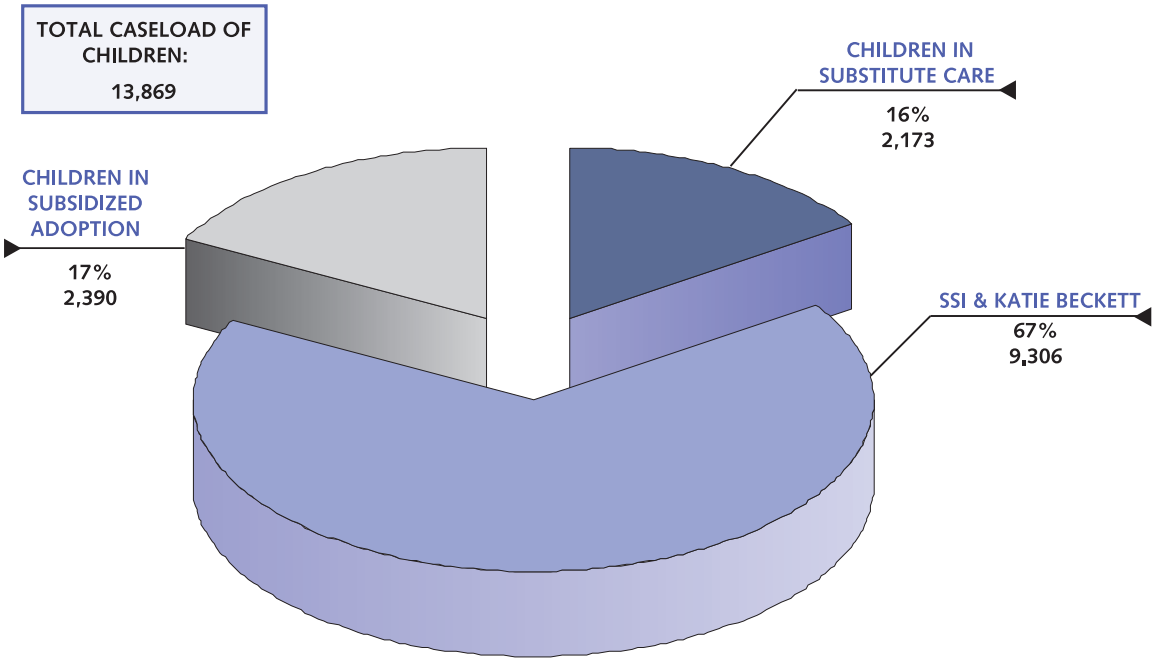
Exhibit 20 displays the distribution of the three sub-populations, of the total 13,896 children with special health care needs in FY 2004:

- 9,308 children in SSI or Katie Beckett
- 2,390 children in subsidized adoption
- 2,173 children in substitute care

Exhibit 21 displays the distribution of the three sub-populations in terms of total expenditures of $192 million , that is:

- $98 million for SSI and Katie Beckett
- $82 million for children in substitute care
- $12 million for children in subsidized adoption

EXHIBIT 20
Caseload Distribution of Children with Special Health Care Needs
SFY 2004



CHILD & FAMILY HEALTH POPULATION & SERVICE EXPENDITURES - CONTINUED

EXHIBIT 21
Expenditures for Children with Special Health Care Needs by Population Subgroup SFY 2004

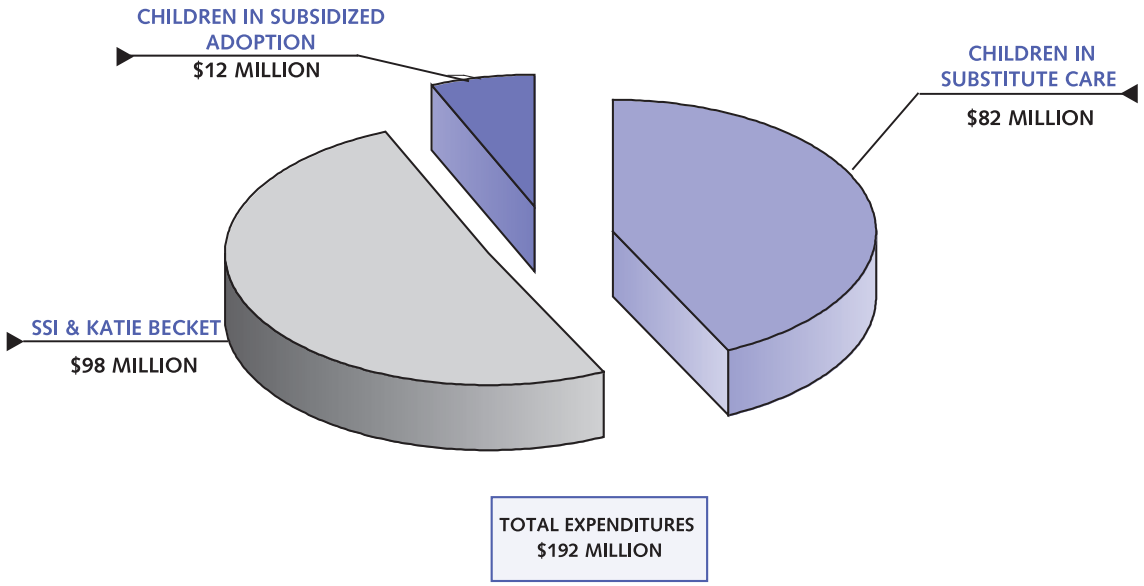
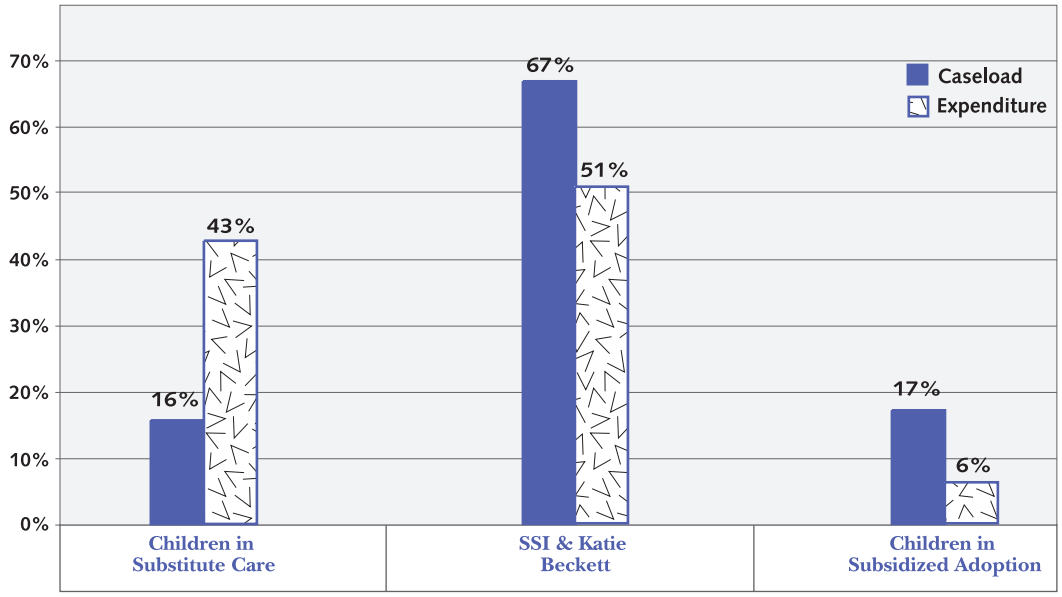


Exhibit 22 compares caseload and expenditures for the three subpopulations. Children in substitute care represent 16% of the total special needs population and 43% of the expenditures. Children in SSI or Katie Beckett represent 67% of the special needs population and 51% of the expenditures. Children in subsidized adoption represent 17% of the population and only 6% of the expenditures.

EXHIBIT 22
Children with Special Health Care Needs - Percent Caseload vs Percent Expenditures by Population Subgroup SFY 2004

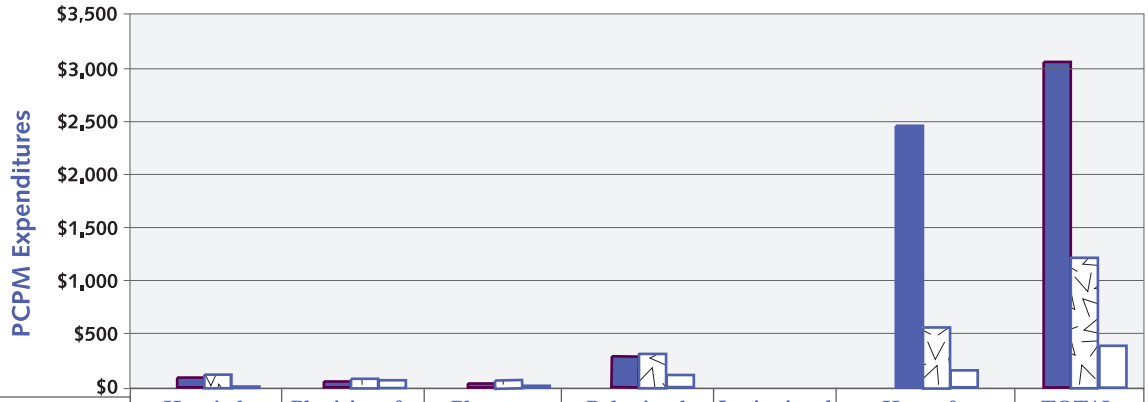


CHILD & FAMILY HEALTH POPULATION & SERVICE EXPENDITURES - CONTINUED

Exhibit 23 compares PCPM expenditures by service provider category. By far, children in substitute care have the highest PCPM at $3,061. For all three populations home and community based services represent the largest expenditure category.

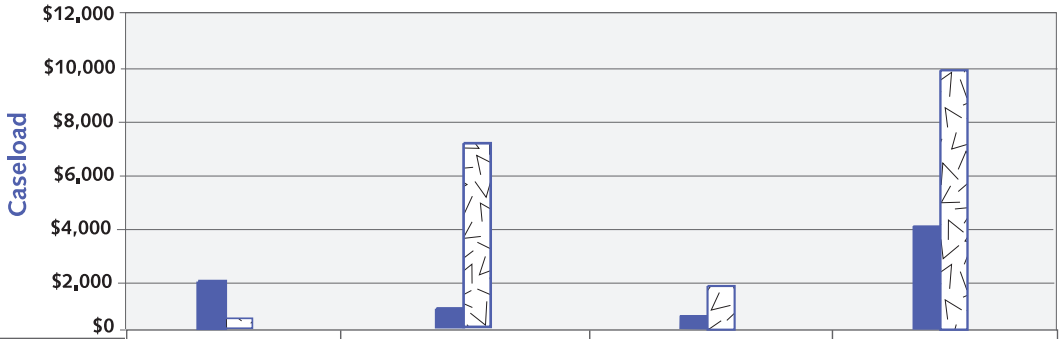
Exhibit 24 displays the number of children with special health care needs by sub-population enrolled in RIte Care or remaining in fee-for -service Medicaid as of June 30, 2004. Approximately one-third of the total population was enrolled in RIte Care.

EXHIBIT 23
Children with Special Health Care Needs by Population Subgroup, PCPM by Service Provider SFY2004



Service Provider Category	Hospital	Physicians & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services	TOTAL
Children in Substitute Care	$123	$87	$67	$324	--	$2,460	**$3,061**
SSI & Katie Beckett	$143	$94	$81	$336	$2	$580	**$1,236**
Children in Subsidized Adoption	$17	$31	$36	$144	--	$191	**$418**

EXHIBIT 24
Children with Special Health Care Needs RIte Care vs. Fee for Service SFY 2004



Service Provider Category	Children in Substitute Care	SSI & Katie Beckett	Children in Subsidized Adoption	TOTAL
RIte Care	2,015	1,573	488	**4,076**
Fee For Service	158	7,733	1,902	**9,793**

TRACKING ACCESS, QUALITY & OUTCOMES

CHILDREN & FAMILIES IN MANAGED CARE

In order to measure RIte Care's impact on health care access, quality and outcomes, Rhode Island Medicaid established the Research and Evaluation Project within the Division for Health Care Quality, Financing and Purchasing. The Research and Evaluation Project evaluates what programs work and how change occurs.

Throughout most of the 1990s, research and evaluation efforts focused on the children and families enrolled in RIte Care. As the RIte Care evaluation began to show that the program had a positive impact on health status and outcomes for the target population, Medicaid began expanding the Research and Evaluation Project to other population groups.

For the past eight years, Medicaid has been measuring RIte Care's access, quality and outcome effects. This has allowed the program to track progress in the health and health care of the population over time. RIte Care enrollees have experienced significant improvements in their access to health care and health status, including primary, pediatric, and prenatal care, increased inter-birth intervals, decreased maternal smoking, positive trends in low-birth weight among RIte Care newborns, and increased childhood immunization and lead screening rates as follows:

- Decrease in the uninsured population. Rhode Island's coverage expansions have decreased the uninsurance rate of children. The percentage of uninsured children in Rhode Island had dropped from 12.5 percent in 1995 to 2.4 percent in 2000, the lowest in the nation. Unfortunately, as a result of erosion in employer sponsored coverage uninsured children in Rhode Island increased to 5.2% in 2003.
- Increased inter-birth interval. RIte Care has positively impacted maternal health. An increasing number of women on Medicaid wait at least 18 months between births, from 60 percent before RIte Care implementation (1993-94) to 68.7 percent in 2002. Women receiving Medicaid and those with commercial health insurance now have inter-birth intervals of similar length.
- Reduction in smoking during pregnancy. The percent of pregnant women on Medicaid who smoked during pregnancy decreased significantly, from 32 percent in 1993 to 20.6 percent in 2002.
- Improved access to prenatal care. In 2002, 82.4 percent of women on Medicaid began prenatal care in the first trimester, up from 77 percent in 1993.
- Increased adequacy of prenatal care. The number of women on Medicaid receiving adequate prenatal care increased significantly, from 56 percent in 1993 to 72.1 percent in 2002.

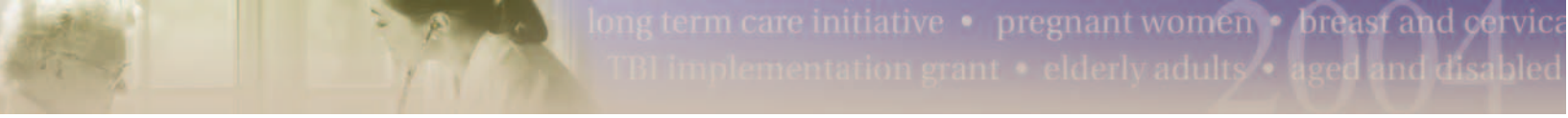
CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Recent studies on children with special health care needs indicated room for improvement in the care of these children. Central are the opportunities to enhance quality, access and coordination of care for children with special health care needs. The State has built on RIte Care's successes by enrolling children with special health care needs into the program's participating health plans in FY 2004.

In calendar year 2000 [5], 12,062 children were enrolled in the four subgroups that encompass children with special health care needs: children eligible due to SSI (45%); children in subsidized adoptions (38%); children eligible due to the Katie Beckett provision (8%) and children in foster care (substitute placement) (8%). The DHS reviewed utilization data for these children, finding:

- The annual hospitalization rate per 1,000 individuals was 173. Children in foster care (substitute placement) had the highest rate of hospitalization, at 262 per 1,000 children.
- Mental disorders were the leading cause of hospitalization for all four groups. Eighty-seven percent of hospitalizations for children in foster care were for mental disorders.
- Over 7 percent of all children with special health care needs were hospitalized. Of those hospitalized, over 21% had a length of stay greater that 30 days. Thirty-two percent of children in foster care were hospitalized for longer than 30 days.
- Mental disorders were the leading cause of hospitalization for all four groups. Eighty-seven percent of hospitalizations for children in foster care were for mental disorders.
- Fifty-seven percent of the children with hospitalizations were admitted more than once.
- The emergency department visit rate for children with special health care needs was 443 per 1,000. Children enrolled due to SSI eligibility have the highest rate of emergency department visits, at 599 per 1,000.

5 Calendar year 2000 is the most recent year for which utilization information is available



WEB SITE LINKS

Look on the DHS web site: www.dhs.ri.gov for the following links to find more information about topics discussed in this report.

- What is Medicaid?
  - History of Medicaid
- How is RI Medicaid Administered?
  - Partnerships for Serving the RI Medicaid Population
- Who is Eligible?
- What Services are covered?
- How is Medicaid Financed?
- How is Rhode Island's Medicaid Budget Determined
  - Caseload Projections & Budget Forecasts
- What is a Waiver?
- Research & Evaluation Project
  - 2001 description
  - Evaluation Studies Work Group
- How to apply for Medicaid, RIte Care or RIte Share

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- **Payne, Christine,** Needs Assessment Survey of RI Working-Age Adults with Physical Disabilities and Chronic Health Conditions on Fee-for-Service Medicaid, February 2002.
- **Payne, Christine,** Hospital and Emergency Department Utilization for Working-Age Rhode Islanders on Fee-For-Service Medicaid, A Health Service Indicator Trends Report: 1998-2000. May 2002.

See **http://www.ritecareresearch** *for a comprensive library of research reports and issue briefs.*

ACKNOWLEDGEMENTS

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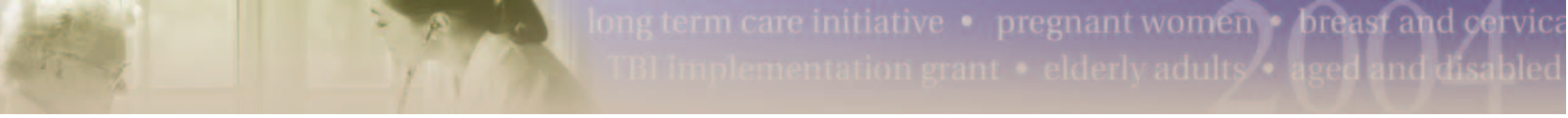

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